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PUSHING BACK: PROTECTING MATERNAL AUTONOMY
FROM THE LIVING ROOM TO THE DELIVERY ROOM

BENJAMIN GRANT CHOJNACKI¹

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I. INTRODUCTION

On the surface, technological advancements giving mothers-to-be the choice to have a C-section or schedule an induction without a medical reason² and the continued legalization of Direct-Entry Midwifery appear to indicate that mothers are enjoying a greater amount of choice in selecting their method of childbirth. But a closer examination reveals that, despite “the social and cultural movement directed toward affording pregnant, laboring, and birthing women greater autonomy and control during this vital reproductive process,”³ limits on maternal autonomy still exist.⁴ As more women deliver their children using Direct-Entry Midwives, through elective C-sections, or through scheduled induction, these limits have the potential to grow more intense.

This perverse effect is the result of a flawed system,⁵ and changes can be made to protect maternal autonomy from the consequences of these flaws.⁶ Part II provides an overview of “new” delivery options available to pregnant women today. Part III examines how courts, legislators, health care providers, birth advocates, and insurers

² This note will refer to C-sections requested and performed without a medical reason as “elective C-sections,” and induced labor scheduled without a medical reason as “scheduled induction.”

³ Suzanne K. Ketler, *The Rebirth of Informed Consent: A Cultural Analysis of the Informed Consent Doctrine After Schreiber v. Physicians Ins. Co Wisc.*, 95 NW. L. REV. 1029, 1029 (2001).

⁴ For a review of these limitations and some contemporary criticism of American maternity care, see generally JENNIFER BLOCK, PUSHED : THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE 1-24 (Da Capo Press 2007); MARS DEN WAGNER, BORN IN THE U.S.A: HOW A BROKEN MATERNITY SYSTEM MUST BE FIXED TO PUT WOMEN AND CHILDREN FIRST 102 (University of California Press 2006).

⁵ See WAGNER, *supra* note 4, at 4 (arguing that the fundamental flaw in American maternity care is that highly trained obstetricians are regularly attending normal and low risk pregnancies); BLOCK *supra* note 4 (highlighting several flaws in modern maternity care).

⁶ This note builds on the suggestions and recommendations of many commentators. See WAGNER, *supra* note 4, 205-09 (advocating for increased accountability and transparency throughout pregnancy); Sylvia A. Law, *Childbirth: An Opportunity for Choice That Should Be Supported*, 32 N.Y.U. L. REV. & SOC. CHANGE 345, 362 (2008) (arguing that, where professional opinion is in conflict and women bring different birth values to the birth experience, the voices of women should be given greater weight); Ketler, *supra* note 4, at 1055-56 (discussing informed consent); Margaret M. Donohoe, *Our Epidemic of Unnecessary Cesarean Sections: The Role of the Law in Creating It, the Role of the Law in Stopping It*, 11 WIS. WOMEN’S L.J. 197, 201-02, 238-40 (1996) (documenting the rise of unnecessary C-sections and arguing that government agencies should provide women with accurate, physician-specific information on hospital and individual physician’s C-section usage).

limit a mother's ability to choose what she believes to be the best delivery option. Part IV argues that as more women begin to have home births,⁷ elective C-sections, and scheduled inductions, the limits on maternal choice will grow more intense. Part V suggests changes to combat these pressures and to protect a mother's independence during labor. This portion achieves its goal by offering a three-tiered approach to empower women to make well-informed delivery choices. This three-tiered approach includes: (1) empowering the mother as a decision maker by providing her with more information and creating a system of disinterested health care provider education; (2) offering economic incentives to freestanding alternative birth centers and physicians, to make alternative services more appealing; and (3) reforming informed consent to facilitate greater dialogue between physician and patient.

II. "NEW" BIRTH OPTIONS

In the past, legal restrictions, financial considerations, or circumstances surrounding maternal or fetal health have limited the delivery choices a mother could exercise.⁸ In recent years, however, progressive legislative efforts and changing medical standards have given American mothers a growing number of options when deciding how they will give birth. While the number of women opting to exercise some of these options is small,⁹ it is possible that these methods will grow more popular.¹⁰ The following portion discusses several of these options.

A. *Midwifery & Home Births*

1. Midwifery—An Overview

Midwifery is becoming an increasingly acceptable delivery option for American mothers.¹¹ Throughout much of the industrialized world, the practice is recognized

⁷ For a discussion of home births, *see infra* Part II.

⁸ *See infra* Part III.

⁹ Nearly 100 percent of all births in the United States in 2000 took place in a hospital. Joyce A. Martin et al., *Births: Final Data for 2000*, 50 NAT'L VITAL STAT. REP. Feb. 2002, at 14, 71. It is not certain how many mothers are actually opting to undergo an elective C-section without a medical reason. Law, *supra* note 6, at 353-54.

¹⁰ *See infra* notes 11, 34, & 76 and accompanying text.

¹¹ As of July 10, 2007, twenty five states allow Direct-Entry Midwives to practice after obtaining some licensure or certification, ten states and the District of Columbia prohibit the practice, four states do not prohibit or regulate them, in two states the practice is legal but licensure is unavailable, and nine states allow the practice by judicial or statutory interpretation. Midwives Alliance of North America, *Direct-Entry Midwifery State-By-State Legal Status*, www.mana.org/statechart.htm (last visited Aug. 25, 2009); *see also* Christopher Rausch, *The Midwives and the Forceps: The Wild Terrain of Midwifery Law in the United States and Where North Dakota is Heading in the Birthing Debate*, 84 N. DAK. L. REV. 219, 230-31 (2008); Bruce Hoffman, *Minding the Gap: Legal Ideals and Strategic Action in State Legislative Hearings*, 33 LAW & SOC. INQUIRY 89, 94-99 (2008). Dr. Marsden Wagner Reports that in the past ten years, Midwife attended births have increased from five to nine percent. WAGNER, *supra* note 4 at 10.

as an essential part of effective maternity care.¹² In most industrialized nations, midwives attend low-risk births, while trained obstetricians only attend dangerous deliveries, where their advanced knowledge and skill can be put to use.¹³ Such a system does not exist in America today.¹⁴ The vast majority of deliveries in America today occur in hospitals under the supervision of trained obstetricians.¹⁵

Midwives and physicians differ in their philosophical approach to pregnancy.¹⁶ Unlike physicians, who typically have a “disease oriented approach” to treatment, midwives typically apply a “wellness approach.”¹⁷ The “disease-oriented approach” focuses on the diagnosis and treatment of pregnancy complications and the “management of diseases affecting pregnant women and the fetuses they carry.”¹⁸ When applied, this “no case is normal until it’s over” philosophy may be contributing to the ever-increasing number of obstetrical interventions throughout pregnancy.¹⁹ Midwives, on the other hand, apply the more holistic and hands-off “wellness approach,” wherein a great deal of trust is placed into the body’s ability to bring about a safe delivery and medical intervention is avoided until absolutely necessary.²⁰ Some have suggested that this approach is not financially attractive to hospitals because it results in longer deliveries that lessen the number of potential patients, and does not provide hospitals the opportunity to make a profit through administering billable procedures.²¹

¹² In Australia, the Netherlands, Great Britain, all Scandinavian countries, Germany, Ireland, and other industrialized nations more than seventy-five percent of all births are assisted by trained midwives. WAGNER, *supra* note 4, at 4.

¹³ In most European nations, obstetricians attend between ten to fifteen percent of births. *Id.* at 5.

¹⁴ *Id.* at 4-5.

¹⁵ Nearly 100 percent of all births in the United States in 2000 took place in a hospital. Joyce A. Martin et al., *Births: Final Data for 2000*, 50 NAT’L VITAL STAT. REP. Feb. 2002, at 14, 71. Obstetricians attended nearly ninety percent of those births. WAGNER, *supra* note 4, at 5.

¹⁶ See generally Laura D. Hermer, *Midwifery: Strategies on the Road to Universal Legalization*, 13 HEALTH MATRIX 325, 329-35 (2003) (explaining the differences in health care provider treatment philosophies).

¹⁷ *Id.*

¹⁸ *Id.* at 329-30 (citing to JUDITH PENCE ROOKS, *MIDWIFERY AND CHILDBIRTH IN AMERICA* 4 (Temple University Press 1997)).

¹⁹ *Id.* at 331.

²⁰ *Id.* at 332.

²¹ BLOCK, *supra* note 4, at 66. At the same time, because midwives are paid less than physicians and the non-interventionist approach reduces the number of unnecessary medical interventions, the midwife model of care has been lauded as offering a significantly less expensive method of childbirth. WAGNER, *supra* note 4 at 39, 121; Rausch, *supra* note 11, at 229. Some have asserted that the economic threat that out-of-hospital birth presents to the mainstream medical community is a factor contributing to restrictive midwifery laws. See Amy F. Cohen, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L. J. 849, 854 (2005).

Regardless of their profit value, midwives have been providing birthing mothers with a valuable service for centuries.²² Midwife advocates boast that the practice is the oldest form of maternity care.²³ But today's midwives are much different from their old-world predecessors.²⁴ Midwifery in America has evolved into a trade whose practitioners possess highly developed skills and training.²⁵ As the practice has evolved, different midwifery classifications have developed.

The two primary midwife classifications are Certified Nurse Midwives and Direct-Entry Midwives.²⁶ Every American jurisdiction permits Certified Nurse Midwives to practice within its borders.²⁷ Certified Nurse Midwives are formally educated nurses who acquire a nursing degree and then complete further study in Obstetrics and Gynecology before passing a certification examination.²⁸ Typically, a Certified Nurse Midwife will practice in an institutional setting under a physician's direct control.²⁹

Unlike their formally trained counterparts, Direct-Entry Midwives often take less traditional routes to practice. Some Direct-Entry Midwives are educated through informal routes such as self-study or apprenticeship, rather than through a formal program.³⁰ While many Direct-Entry Midwives can become certified through either the North American Registry of Midwives (NARM) or the American College of Nurse-Midwives (ACNM),³¹ "not all Direct-Entry Midwives are certified."³² Some avoid certification because they view the training as harmful or irrelevant, while

²² Women have been aiding each other throughout birth since the early civilizations. M. Brucker, *A History of Midwifery*, <http://www3.utsouthwestern.edu/midwifery/mdwf/history.html> (last visited Feb. 11, 2009); see also Rausch, *supra* note 11, at 224-25 (2008) (reviewing the history of midwives). Females dominated the practice through the eighteenth century, until gynecology and surgery began to be studied by academics. *Id.* (citing to BRIAN E. BURTCHE, TRIALS OF LABOUR: THE RE-EMERGENCE OF MIDWIFERY 80 (1994)).

²³ See generally Rausch, *supra* note 11, at 224.

²⁴ *Id.* at 224-227.

²⁵ See *infra* notes 26-33 and accompanying text.

²⁶ See generally Noralyn O. Harlow, Annotation, *Midwifery: State Regulation*, 59 A.L.R. 4th 929, 932 (1988). Direct-Entry Midwives are also referred to as "lay" midwives, for the sake of uniformity, this Note will only use the term "Direct-Entry Midwives."

²⁷ WAGNER, *supra* note 4, at 102.

²⁸ Harlow, *supra* note 26.

²⁹ *Id.* (citing to Debra Evenson, *Midwives: Survival of an Ancient Profession*, 7 WOMEN'S RTS. L. REP. 313, 314 (1982)).

³⁰ See generally Harlow, *supra* note 26; Rausch, *supra* note 11, at 223.

³¹ NARM is an international certification agency created by the Midwives' Alliance of North America ("MANA") "to create [an] internationally accepted direct-entry midwifery credential to preserve the unique, woman-centered forms of practice that are common to midwives attending out-of-hospital births." North American Registry of Midwives, *NARM Mission Statement*, <http://www.narm.org/mission.htm> (last visited Dec. 27 2008). See generally Hermer, *supra* note 16, at 334 (discussing the NARM and ACNM certifications).

³² Hermer, *supra* note 16 at 334.

others practice illegally in states that do not permit them to attend births. Finally, others simply lack the education, skills, or training needed to gain certification.³³

2. A More Appealing Approach?

Despite their lack of formal training, more women are utilizing Direct-Entry Midwives.³⁴ In applying the more holistic “wellness approach,” Direct-Entry Midwives offer mothers in low-risk pregnancies a birthing option that removes the mother from the hospital and gives her a great deal of freedom during labor.³⁵ Unlike Certified Nurse Midwives, Direct-Entry Midwives typically attend home births.³⁶ In a home birth, a laboring woman will usually deliver from her own house and will remain with her baby after the delivery.³⁷ As Direct-Entry Midwifery becomes increasingly available, the number of women choosing home births appears to be increasing.³⁸

The freedom offered by home births lies in stark contrast to what may be experienced in a hospital setting. In the hospital, once labor begins, mothers are often physically restricted to their hospital bed so that the fetal heart rate may be tracked using Electronic Fetal Monitors (EFMs).³⁹ Despite little evidence supporting their efficacy, EFMs are the “presumptive standard of care”⁴⁰ in the hospital.⁴¹ Two rationales support making EFMs the standard. First, EFMs are a more cost effective method for monitoring fetal heart rate,⁴² and second, they provide concrete evidence

³³ *Id.* Many illegally practicing midwives could only learn the trade through apprenticeships, because these midwives have been successfully delivering children without formal education, some see no reason to reason to further their education. *Id.*

³⁴ The midwife and home birth movement has grown increasingly popular in recent years. Julie Scelfo, *Midwives Say Home Births Are Up, Despite Warnings*, N.Y. TIMES, Nov. 12, 2008, available at http://www.nytimes.com/2008/11/13/garden/13birth.html?pagewanted=1&_r=2 (last visited Nov. 23, 2008) (documenting the increased number of women choosing home births in New York City). Since 2007, a popular documentary and several books have been produced claiming to expose many problems with American maternity care and proposing that the solution for many women is to get out of the hospital and back into the home. See, e.g., THE BUSINESS OF BEING BORN (New Line Home Video 2007); BLOCK, *supra* note 4, at 268.

³⁵ See *infra* notes 36-48 and accompanying text. In home births, mothers can set the environment according to their liking and freely move about without the fear of unnecessary medical intervention. This is in stark contrast to being constrained to a bed and hooked to Electronic Fetal Monitors (EFMs), as is the presumptive standard of care in hospitals.

³⁶ Hermer, *supra* note 16, at 334; see also Rausch, *supra* note 11, at 223-25.

³⁷ Scelfo, *supra* note 34.

³⁸ *Id.*; Cf. BLOCK, *supra* note 4 at 268 (documenting the emerging birthing rights movement).

³⁹ Law, *supra* note 6, at 361-62 (explaining the use of EFMs).

⁴⁰ *Id.* at 362 (quoting H. David Banta & Stephen B. Thacker, *Historical Controversy in Health Technology Assessment: The Case of Electronic Fetal Monitoring*, 56 OBSTETRICAL & GYNECOLOGICAL SURV. 707, 714 (2001)).

⁴¹ *Id.*

⁴² *Id.*

should an accident occur.⁴³ Home births are attractive, in part because they offer mothers the chance to deliver in the comfort of their own home, free from the restrictive EFMs, with little or no medication, and the freedom to move as they please.⁴⁴

Freedom is not the only reason that some opt to deliver via home births.⁴⁵ For many, choosing to deliver away from the hospital is a choice that reflects spiritual, religious, political, and feminist beliefs.⁴⁶ It is important to understand how firmly some mothers hold these beliefs.⁴⁷ Trivializing this important point creates misunderstandings between lawmakers, physicians, and patients.⁴⁸

3. Concerns Surrounding Home Births

Despite the increased acceptance of home birth as a valid birth option, criticisms about its safety persist.⁴⁹ Because midwives are not infallible and serious complications can turn low-risk pregnancies into high-risk deliveries with no warning,⁵⁰ some suggest that the option needlessly risks the health and safety of both mother and child.⁵¹ Fetal injuries may occur because home births create distance between mothers, skilled obstetricians, and valuable hospital equipment.⁵² Others are concerned by Direct-Entry Midwives' lack of formal education.⁵³

⁴⁴ Scelfo, *supra* note 34.

⁴⁵ Cohen, *supra* note 21, at 858-62.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ See, e.g., *id.* at 854-62, 880 (arguing that midwifery advocates have not clearly communicated the numerous facets of their beliefs about childbirth to other parties).

⁴⁹ Whether or not these concerns are justified is unclear. The data concerning the safety of delivering with a midwife suggests that for low-risk births, delivering with a midwife is a safe choice. See generally BLOCK, *supra* note 4, at 95,264; WAGNER, *supra* note 4 at 35, 130; Hermer, *supra* note 16, at 339-48; Rausch, *supra* note 11, at 227-30.

⁵⁰ Joseph Heyman, Letter to Editor, L.A. TIMES July 23, 2008 available at <http://www.ama-assn.org/ama/pub/category/18830.html> (last accessed Nov. 21, 2008). Dr. Heyman is Chairman of the Board of Trustees for the American Medical Association. See also Rausch, *supra* note 11, at 229-30. States have attempted to combat these dangers by requiring that Certified Nurse Midwives & Direct-Entry Midwives have written "supervisor" or "consultant" agreements with an obstetrician. WAGNER, *supra* note 4, at 132.

⁵¹ Heyman, *supra* note 50.

⁵² Cf. Ramsay v. Good Samaritan Hospital, 808 N.Y.S.2d 374 (2005) (granting defendant-physician's motion to dismiss because physician was not present at home delivery attended by midwife).

⁵³ See WAGNER, *supra* note 4, at 118-19 (documenting that at state legislative hearings considering legalizing Direct-Entry Midwifery, the common criticism lobbied against midwives was that delivering outside the hospital is "not safe.").

Midwives often defend against health concerns by explaining that the option is only available to mothers in low-risk births.⁵⁴ Studies have also demonstrated that the use of midwives is “just as safe, if not safer than medical care in low risk childbirth.”⁵⁵ But at least some empirical evidence suggests that despite only taking on low-risk births, home births may be more dangerous than delivering in a hospital.⁵⁶ This may be because no dependable method exists to predict if or when a low-risk pregnancy may turn dangerous.⁵⁷

4. Questionable Support

Even in states where Direct-Entry Midwifery is allowed, it is not always viewed favorably. In 2007, Missouri added its name to the growing number of states legalizing Direct-Entry Midwifery.⁵⁸ The bill legalizing the practice, House Bill 818,⁵⁹ passed in large part because of creative draftsmanship, and not because of genuine legislative support.⁶⁰ House Bill 818,⁶¹ a 123 page bill dealing with health insurance, never once mentioned midwifery.⁶² Instead, Senator John Loudan buried language into the tail end of the bill permitting “any person who holds tocological certification ... [to] provide services as defined in 42 U.S.C. § 1396r-

⁵⁴ WAGNER, *supra* note 4, at 41; Rausch, *supra* note 11, at 229-30; Cohen, *supra* note 21, at 858-59.

⁵⁵ Hermer, *supra* note 16, at 326; *see also* Rausch, *supra* note 11, at 227-229 (summarizing the statistical support for the safety of midwifery).

⁵⁶ Mr. Rausch discusses several of these studies. *See* Rausch, *supra* note 11, at 229-30. Mr. Rausch highlighted that one study has shown that physicians are far more successful than midwives under certain circumstances. *See id.* (citing to Lewis Mehl-Madrona & Morgaine Mehl-Madrona, *Physician and Midwife-Attended Home Births: Effects of Breech, Twin and Post-Dates Outcome Data on Mortality Rates*, 42 J. NURSE MIDWIFERY 91, 95 (1997)). That study showed that the infant mortality rate is over three times higher in home births involving post-date, twin, or breech deliveries. *Id.* Others have also reached the similar conclusions. *See* Amy Tuteur, *New Wisconsin Statistics Continue to Show High Homebirth Death Rate*, www.homebirthdebate.blogspot.com (citing to http://dhs.wisconsin.gov/wish/measures/inf_mort/long_form.html) (last visited Jan. 23, 2009). Dr. Tuteur examined statistics compiled by the state of Wisconsin and concluded that they suggest that the neonatal death rate for home births attended by lay midwives are nearly three times higher than those low risk births performed in hospitals.

⁵⁷ Rausch, *supra* note 11, at 229. *See also* Scelfo, *supra* note 34 (quoting Dr. Erin Tracey).

⁵⁸ MO. REV. STAT. § 376.1753 (LexisNexis 2008).

⁵⁹ H.B. 818, 94th Gen. Assem., First Reg. Sess. (Mo. 2007).

⁶⁰ The Missouri legislature had expressly refused to create a licensing board for Direct-Entry midwives earlier in the 2007 legislative session. *See* S. 303, 94th Gen. Assem., Reg. Sess. (Mo. 2007). *See also* Matthew Franck, *Midwives Bill Slips Through Missouri Legislature*, ST. LOUIS POST-DISPATCH May 15, 2007, at A1, available at <http://www.stltoday.com/stltoday/news/special/srlinks.nsf/story/F661D676A70DF7CF862572DC007A159E?OpenDocument>. (last visited Dec. 2, 2008).

⁶¹ Mo. H.B.818.

⁶² *Id.*

6(b)(4)(E)(ii)(I).”⁶³ The addition went unnoticed until shortly after the Missouri Congress passed the bill, at which point senators unsuccessfully attempted to nix the legislation before it was signed into effect.⁶⁴ Following its enactment, Senator Loudan was briefly removed from his position as Chair of the Senate Small Business Committee⁶⁵ and a lawsuit brought by several physicians’ associations was heard before the Missouri Supreme Court.⁶⁶

The frenzy surrounding Direct-Entry Midwives polarized many within Missouri.⁶⁷ And while Direct-Entry Midwifery is now a legal practice,⁶⁸ the battle fought over its legalization has contributed to the sometimes hostile relationship between doctors and midwives.⁶⁹ As midwifery grows more popular, such relationships could diminish the quality of healthcare available to mothers.

B. Elective C-Sections

Physicians have been performing C-sections in emergencies for some time.⁷⁰ While the procedure is major surgery,⁷¹ C-sections have become safe⁷² enough that

⁶³ *Id.* Sen. Loudan made certain that the meaning of this provision would not be easily determinable on first glance. 42 U.S.C. § 1396r-6(b)(4)(E)(ii)(I) (2008) permits for an additional six month extension of emergency medical assistance for services related to pregnancy. And “tocological certification” is a derivative of the Greek term “tokos,” meaning childbirth. Franck, *supra* note 60. “Tocology” is defined as the science of obstetrics and midwifery. *Id.*

⁶⁴ Franck, *supra* note 60.

⁶⁵ *Id.*

⁶⁶ *Mo. State Med. Ass’n v. State*, 256 S.W. 3d 85 (Mo. 2007) (reversing trial court judgment finding the statute constitutionally invalid because the plaintiffs lacked standing to bring suit).

⁶⁷ Franck, *supra* note 60.

⁶⁸ *See, e.g., Mo. State Med Ass’n*, 526 S.W.3d at 86.

⁶⁹ WAGNER, *supra* note 4, at 115.

⁷⁰ Elena Conis, *Cesarean Section’s Ancient History*, LA Times, May 1 2006 at F-3, available at <http://articles.latimes.com/2006/may/01/health/he-esoterica1> (last visited Feb 12, 2009). Early Chinese drawings depict newborns being removed from openings in their mother’s abdomen and ancient Roman law required babies to be surgically removed when the mother died before or during labor. *Id.* The procedure was generally performed only where the mother had little chance for survival or was already dead until the late middle ages. *Id.* Women began surviving the procedure with some regularity in the 18th century. *Id.* It has since become a common procedure throughout the civilized world. *Id.* Since the 1970’s, America’s high C-section rate has been the subject of much criticism. *See generally* BLOCK, *supra* note 4, at 109-13; Law, *supra* note 6 at 345-46. In 2007 America’s C-section rate rose for the eleventh consecutive year, reaching an all time high of thirty-one and eight tenths percent. *See* Ctrs. for Disease Control & Prevention, *Nat’l Vital Stats. Reports, Births: Preliminary Data for 2007*, available at http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_12.pdf (last visited Aug. 25, 2009). International studies show that when the C-section rate is between ten and fifteen percent, the maternal mortality rate decreases. WAGNER, *supra* note 4, at 42, 47-48 (citing to and explaining the methodology leading to the World Health Organization’s conclusion and consistent recommendations that a ten to fifteen percent C-section rate is the optimal rate for maternal and fetal health).

physicians may give mothers the option to request that their child be delivered using this method without a medical reason.⁷³ There is a professional consensus that, at a woman's request, it is medically acceptable and sometimes ethically responsible to perform C-sections without a medical reason.⁷⁴ Although the number of women requesting elective C-sections is small,⁷⁵ it is possible that more women will opt to deliver in this fashion.⁷⁶

⁷¹A physician performs a cesarean delivery by making an incision in the abdominal wall and uterus (rather than through the vagina) the amniotic fluid is suctioned out and then the baby is delivered. American Pregnancy Association, *Cesarean Procedure*, <http://www.americanpregnancy.org/labornbirth/cesareanprocedure.html> (last visited Nov. 21, 2008). The normal cesarean procedure will take an average of forty-five minutes to an hour. The baby is usually delivered in the first five to fifteen minutes and the remainder of time is used for closing the incision. *Id.* This is much quicker than the typical vaginal delivery. WAGNER, *supra* note 4, at 38-44.

⁷²The dangers presented by C-sections are well documented. *See* WAGNER, *supra* note 4 at 44-45. Dr. Wagner posits that women who choose C-sections do not appreciate the risk they are taking. *Id.* Despite the risks, Professor Law argues that elective C-sections are a justifiable choice for women to make. Law, *supra* note 6 at 346.

⁷³This position has garnered more acceptance in the past decade. In 2003, The American College of Obstetricians and Gynecologists ("ACOG") stated that it was sometimes medically and ethically responsible for a physician to perform a C-section without a medical reason, and in 2006, the National Institute of Health ("NIH") recognized that in some circumstances that elective C-section might be a reasonable alternative to planned vaginal delivery. *See generally* BLOCK, *supra* note 4 at 56; Law, *supra* note 6, at 347, 353. Professor Law offers a thorough discussion of the motives and rationales of those who choose to exercise this option. *See id.* at 347-54 (discussing the motivations and effects underlying the choice to undergo an elective C-section).

⁷⁴Law, *supra* note 6 at 353. Professor Law supports this position by explaining that the ACOG, the New England Journal of Medicine, and the National Institutes of Health have each reached this conclusion. *Id.* (citing to American College of Obstetricians & Gynecologists, *Surgery and Patient Choice*, Op. No. 289 11 (2003); Howard Minkoff & Frank Chervenak, *Elective Primary Cesarean Delivery*, 348 *NEW ENG. J. Med.* 946 (2003); Nat'l Insts. of Health, *State-of-the-Science Conference Statement, Cesarean Delivery on Maternal Request*, March 27-29, at 14). Professor Law further notes that surveys show that practicing physicians have a wide range of attitudes towards performing C-sections without a medical reason. *Id.* at 353.

⁷⁵*See* Law, *supra* note 6, at 353 (citing to Childbirth Connection's "Listening to Mothers" survey documenting that only one out of one thousand three hundred women reported requesting a C-section).

⁷⁶Evidence suggests that the number of women opting to have a C-section without a medical reason may be increasing. *See* BLOCK, *supra* note 4 at 52 (documenting that, in at least one hospital, physicians reported that one out of every approximately sixty women are making unprompted requests for elective C-sections); *see, e.g.,* Barbara Bettes, et al, *Cesarean Delivery on Maternal Request*, 109 *OBSTETRICS & GYNECOLOGY* 57, 58, 61 (2007) (internal citations omitted) (documenting that more than half of American physicians have either performed a C-section on maternal request or would be willing to do so and in 2006 58% of obstetricians observed an increase in inquiries regarding elective C-section).

C. Induced Labor

American women may also elect to have their labor induced through physician-administered drugs prior to the child initiating the labor process.⁷⁷ Labor is induced using intravenous medication, usually Oxytocin⁷⁸ (or its synthetic form, Pitocin⁷⁹), that brings on contractions in the uterus.⁸⁰ Other methods for inducing labor include rupturing the amniotic sac (breaking the water) or dilating the cervix.⁸¹ Today, approximately fifteen percent of babies born in America are delivered via induced labor.⁸² Although this practice is nothing new, the frequency with which physicians rely upon these medications is often criticized, and is an impetus behind the reaction against “medicalized” birth that is causing some mothers to deliver outside the hospital.⁸³

III. LIMITING MATERNAL AUTONOMY

To understand why exercising these options with greater frequency will lead to diminished maternal choice, it is first important to examine several problems with maternity care in America. A flaw in this “broken”⁸⁴ system is the multitude of ways

⁷⁷American Pregnancy Association, *Inducing Labor*, <http://www.americanpregnancy.org/labornbirth/inducinglabor.html> (last visited Dec. 1, 2008); see also American College of Obstetricians and Gynecologists, *Labor Induction*, http://www.acog.org/publications/patient_education/bp154.cfm (last visited October 19, 2008).

⁷⁸Oxytocin is a hormone produced by the hypothalamus that is stored in and released from the pituitary gland. 1 Am. Jur. 3d *Proof of Facts* 1 (citing to STEPHEN GABBE ET AL., *OBSTETRICS: NORMAL AND PROBLEM PREGNANCIES* 363 (1986)).

⁷⁹1 Am. Jur. 3d *Proof of Facts* 1.

⁸⁰1 Am. Jur. 3d *Proof of Facts* 1.

⁸¹American College of Obstetricians and Gynecologists, *supra* note 77.

⁸²*Id.*

⁸³WAGNER, *supra* note 4, at 78, 85, 130, 190; BLOCK, *supra* note 4, at 14, 41, 268; Cohen, *supra* note 21, at 858. This Note posits that the reaction against medicalized birth will contribute to more combative delivery behavior that may have adverse consequences in some situations.

⁸⁴WAGNER, *supra* note 4, at 1-12. Wagner and others are calling America’s maternity care system “broken” for numerous reasons. Commentators cite to the over-medicalization of maternity care as a primary problem, as well as the illegality of Direct-Entry Midwifery and the difficulty many mothers experience when they wish to attempt to deliver vaginally after a C-section (VBAC). BLOCK, *supra* note 4, at 17-31, 77 (discussing the “active management of labor” and VBAC); WAGNER, *supra* note 4, at 39-40 (explaining that physicians are trained to find problems in dangerous situations and suggesting that the result is that too many women are receiving unnecessary treatment); Cohen, *supra* note 21, at 850 (documenting that many women believe midwifery to be a viable, but unavailable option); Donohoe, *supra* note 6 at 241 (explaining that the root of the unnecessary C-section problem is the physicians “need to ‘do’”). The recent trend towards home births is, in part, a reaction against the over-medicalization of birth pervading American maternity care today. See *supra* note 83. Statistics concerning maternal and fetal mortality rates are often cited to bolster these criticisms. As of 2005, twenty-eight countries have lower maternal mortality rates and forty-one nations have lower infant mortality rates than the United States. World Health Organization, http://www.who.int/reproductive-health/publications/maternal_mortality_2005/

that maternal choice is limited by the government, health care providers, advocacy groups, and insurance companies.⁸⁵ The following portion will examine several factors contributing to this broken system.

A. Legal Basis for Maternal Choice

Before discussing how maternal autonomy is being limited, it is first important to review what rights the law proscribes to pregnant women when determining how they will deliver their child. This section will discuss how physicians may coerce patients into undergoing certain medical procedures in an effort to protect fetal health. Generally, such coercion may infringe upon a woman's right to refuse medical treatment or to be free from unwanted medical intrusion.⁸⁶

This section will also discuss how the government has implemented laws restricting midwifery and freestanding alternative birth centers. Several commentators have suggested that a mother's right to choose alternative modes of childbirth is constitutionally protected.⁸⁷ Although the Supreme Court has not yet found that such a right exists, Amy F. Cohen identifies several arguments to support the contention that a mother's right to make alternative birth choices, like home birth with a Direct-Entry Midwife, is a fundamental right protected by the Fourteenth Amendment.⁸⁸ First, because personal autonomy is at the root of the privacy right,⁸⁹ and childbirth decisions are intensely personal decisions⁹⁰ that present "social, economic, and political, rather than merely medical issues,"⁹¹ the maternal right to choose different birth methods is strongly supported by the right to privacy.⁹²

mme_2005.pdf (last accessed Dec. 1 2008); Central Intelligence Agency, The World Factbook, Infant Mortality Rate, *available at* <https://www.cia.gov/library/publications/the-world-factbook/fields/2091.html> (last accessed Dec. 1 2008).

⁸⁵ See, e.g., BLOCK, *supra* note 4 at 261.

⁸⁶ See generally Pamala Harris, *Compelled Medical Treatment of Pregnant Women: The Balancing of Maternal and Fetal Rights*, 49 CLEV. ST. L. R. 133, 139-40 (2001) ("A competent pregnant woman may, for many reasons, refuse medical treatment that a physician regards as beneficial to the woman, the fetus, or in some instances, both.").

⁸⁷ In advocating for a woman's right to select midwifery, Amy Cohen condensed these arguments into one place. See Cohen, *supra* note 21; see also Charles Wolfson, *Midwives and Home Birth: Social, Medical and Legal Perspectives*, 37 HASTINGS L.J. 909, 935 (1986); Harry M. Caldwell, *Bowland v. Municipal Court Revisited: A Defense Perspective on Unlicensed Midwife Practice in California*, 15 PAC L.J. 19, 29-30 (1983); Dale Elizabeth Walker, Comment, *A Matter of Quality of Births: Mothers and Midwives Shackled by the Medical Establishment and Pennsylvania Law*, 23 DUQ. L. REV. 171, 192-94 (1984); Barbara A. McCormick, *Childbearing and Nurse-Midwives: A Woman's Right to Choose*, 58 N.Y.U. L. REV. 661; 682-97 (1983).

⁸⁸ Cohen, *supra* note 21, at 869-875.

⁸⁹ *Id.* at 870.

⁹⁰ McCormick, *supra* note 87, at 686 (explaining further that denial of the right would impose psychological, physical, social, and financial burdens upon the woman).

⁹¹ Wolfson, *supra* note 87, at 941-42.

⁹² Cohen, *supra* note 21, at 869.

Second, the possibility of surgical invasion implicates the right to bodily integrity.⁹³ Because bodily integrity is “the mainstay of any ... privacy argument,” Ms. Cohen suggests this further supports maternal choice being a fundamental right.⁹⁴ Finally, a woman’s parental authority to make decisions for the upbringing of her family also supports the conclusion that a woman has a fundamental right to choose alternative delivery methods.⁹⁵

As compelling as these arguments may be, whether the Court would recognize that such a right exists is not clear. The Court’s reluctance to recognize “new” fundamental rights may make establishing such a right unlikely.⁹⁶ Ms. Cohen viewed the Supreme Court’s decision in *Lawrence v. Texas*, with its affirmation of the “expansive language on substantive due process, liberty, and the sweet mystery of life”⁹⁷ quoted in *Planned Parenthood v. Casey*, as a harbinger that the Court may expand substantive due process to recognize the right to make alternative birth decisions (midwifery) as a fundamental right.⁹⁸

Since Ms. Cohen’s article, *Gonzales v. Carhart* has further illuminated the Court’s view on substantive due process.⁹⁹ *Carhart* is “the most definitive statement to date from the Roberts Court of its approach to substantive due process methodology.”¹⁰⁰ Northwestern University’s Professor Steven Calabresi reads *Carhart* as marking “a pointed retreat from *Lawrence*.”¹⁰¹ Professor Calabresi argues that *Carhart* demonstrates that “[Justice Kennedy] and four other Justices have recommitted themselves to the narrow, restrained approach of *Glucksberg* in substantive due process cases.”¹⁰² This affirmation of a “cautious, pro-judicial restraint approach suggests a greatly reduced role for the Court in inventing new constitutional rights that is dramatically opposed to the expansive language of *Casey* and *Lawrence*.”¹⁰³ Consequently, it may be unlikely that the Court will find that such a right does exist.

Whether or not the Court will conclude that the right to make alternative childbirth decisions is fundamental is a valuable consideration. Should the Court

⁹³ McCormack, *supra* note 87, at 691.

⁹⁴ *Id.*

⁹⁵ Cohen *supra* note 21, at 872.

⁹⁶ *Id.*

⁹⁷ Stephen Calabresi, *Substantive Due Process After Gonzales v. Carhart*, 106 MICH. L. REV. 1517 (2008).

⁹⁸ Cohen, *supra* note 21.

⁹⁹ 550 U.S. 124 (2007).

¹⁰⁰ Calabresi, *supra* note 97, at 1520.

¹⁰¹ David D. Meyer, *Gonzales v. Carhart and the Hazards of Muddled Scrutiny*, 17 J. L. POL’Y 57, 60 (2008).

¹⁰² Calabresi, *supra* note 97, at 1517. In so reaching this conclusion, Professor Calabresi also points out that the Court never once cites *Lawrence* or the expansive language on substantive due process, liberty, and the sweet mystery of life that the *Lawrence* opinion quoted from *Casey*. *Id.*

¹⁰³ *Id.* at 1520.

revert to the broad *Casey* conception of fundamental rights, as it did in *Lawrence*, then some of the restrictions discussed below may be in violation of this right. Moreover, recognizing that such a right exists could reduce physician paternalism that has been identified as causing unnecessary C-sections¹⁰⁴ and pushing some women to deliver outside the hospital setting.¹⁰⁵

B. Other Legal Interests Affecting Maternal Choice

To comprehend fully why maternal choice is limited, it is necessary to examine briefly the legal interests that the government and health care providers have in a mother's delivery decision. Physicians owe a duty of care to both the mother and her fetus,¹⁰⁶ and the state has a compelling interest in fetal health.¹⁰⁷ Sometimes, a mother's refusal to receive medical treatment conflicts with these interests.¹⁰⁸ When a physician believes the mother's birth decision places fetal health at risk, doctors are faced with an ethical dilemma.¹⁰⁹ The physician can either honor the woman's refusal or "compel her to treatment by seeking a court order."¹¹⁰ The consensus among medical professionals is that such actions are almost never appropriate.¹¹¹ And while courts have held that the decision of whether or not to undergo medical treatment is one that must be honored, others have determined that the mother's right to refuse medical treatment is not absolute, and must be balanced against the state or fetal interests.¹¹² In some unusual circumstances, courts have compelled women to submit to medical intervention.¹¹³ Although interventions are rare, this Note posits

¹⁰⁴ Donohoe, *supra* note 6, at 235-36 (suggesting that doctors interpret the legal treatment of maternal and fetal rights as being in competition with one another, and, as a consequence receive a message that paternalism towards their patients is acceptable). If a mother's right to make childbirth choices is given greater recognition, physician paternalism would conceivably be diminished, as physicians would receive a message that the mother's right to choose is afforded greater legal significance that should not be subordinated to protect the fetus.

¹⁰⁵ Cohen, *supra* note 21, at 858.

¹⁰⁶ See Harris, *supra* note 86, at 140-43.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* See *infra* notes 151-176 and accompanying text.

¹⁰⁹ Harris, *supra* note 86, at 140-43.

¹¹⁰ *Id.* at 134.

¹¹¹ See Linda C. Fentiman, *The New "Fetal Protection": The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children*, 84 DENV. U. L. REV. 537, 569-70 (2006) (noting that the American Medical Association, the American College of Obstetrics and Gynecology, and the American Academy of Pediatrics each have adopted strong positions against compelled medical treatment).

¹¹² See John Alan Cohan, *Judicial Enforcement of Lifesaving Treatment for Unwilling Patients*, 39 CREIGHTON L. REV. 849, 896-911 (2006) (documenting cases involving pregnant women refusing medical treatment).

¹¹³ See generally *Jefferson v. Griffin Spaulding County Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981); *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr.*, 66 F. Supp.2d 1247 (N.D. Fla. 1999). See also April Cherry, *The Detention, Confinement, and Incarceration of Pregnant Women for the Benefit of Fetal Health*, 16 COLUM. J. GENDER & L. 147 (2007) (discussing the

that as home births, and more generally the reaction against medicalized birth of which they are an outgrowth, become more popular, more women will refuse to consent to procedures during hospital deliveries. As more mothers do not consent to what physicians believe to be the appropriate delivery method, the delivery room will become a hostile environment. When conflicts arise in such a hostile environment, courts may be called upon to force mothers to submit to medical treatment. In light of the chaotic circumstances surrounding such deliveries,¹¹⁴ and the government's propensity to protect the fetus from harm,¹¹⁵ this Note posits that an increase in court-compelled medical treatment may result.

C. Governmental Limitations

1. Generally

As pregnancy progresses, the number of government limitations on a mother's birth options increase. Every state has the power to regulate the midwives who practice within its borders.¹¹⁶ Depending upon the state, the government may also restrict choice by limiting where a woman may choose to deliver her child, or by failing to require that certain information be made available for mothers to make birth decisions. The following portion discusses these restrictions before shifting its focus to explore ways that the government limits maternal autonomy to protect fetal health.

2. Birth Centers

Birth centers offer women a delivery choice other than hospitals or the home. Generally, these centers can either be "freestanding" or run in conjunction with a hospital.¹¹⁷ Freestanding alternative birth centers are establishments run by midwives with permanent facilities that operate independent of any hospital affiliation,¹¹⁸ and provide prenatal care only to low-risk child bearing women.¹¹⁹ Freestanding alternative birth centers are not available everywhere.¹²⁰ Presently state

judiciary's use of incarceration, detention, and threats to compel pregnant women to submit to physician decisions regarding medical treatment for the benefit of fetal health); Fentiman, *supra* note 111, at 569 (documenting a 2004 court ordered C-section that was never carried out because the mother, after refusing to consent to a C-section, successfully delivered vaginally at another hospital).

¹¹⁴ "[P]roceedings in court-ordered cesareans are usually procedurally inadequate," Cohen, *supra* note 21, at 866-67 n.75.

¹¹⁵ See *infra* Part III.C.4

¹¹⁶ See generally Hermer, *supra* note 16 (discussing midwifery law in America); Stacy A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61, 68-69 (2004) (discussing current legal status of midwifery in America).

¹¹⁷ WAGNER, *supra* note 4, at 137.

¹¹⁸ *Id.* at 133; See also 902 KY. ADMIN. R. 20:150 (2008).

¹¹⁹ 902 KY. ADMIN. R. 20:150 (2008).

¹²⁰ See, e.g., BLOCK, *supra* note 4 at 106, 267.

regulations specifically governing how birth centers can operate may limit birth center location¹²¹ or the number of centers permissible in one geographic region.¹²² Despite these restrictions, as of 2006, 160 freestanding alternative birth centers existed in the United States.¹²³ But a number of these centers are struggling to stay open, in part because compliance with additional statutory requirements¹²⁴ and high insurance premiums make operating for profit difficult.¹²⁵

To accommodate maternal demand for a less sterile and more homely atmosphere, some hospitals have also begun to offer their own birth centers.¹²⁶ Unfortunately, these options are subject to many of the same criticisms as hospitals.¹²⁷ Hospitals have also tried to accommodate for these demands by offering home-like birth suites.¹²⁸ Even if a mother wishes to deliver in a birth suite, she may not be able to do so because delivering in one can be costly¹²⁹ and reserving a suite does not guarantee that delivery will take place within.¹³⁰

¹²¹ CAL HEALTH & SAFETY CODE § 1204.3 (Deering 2009) (requiring alternative birth centers to be located within 30 minutes in both time and distance from a facility with the capacity to manage obstetrical and neonatal emergencies).

¹²² 210 ILL. COMP. STAT. 3/30(a-25) (2009) (requiring that “[t]here shall be no more than 10 birth center alternative care models . . .”). That section further limits the number of birth centers located throughout the state according to population. *Id.*

¹²³ WAGNER, *supra* note 5, at 137.

¹²⁴ *Id.* at 132 (discussing the “supervisor” and “consultant” relationships that some states require midwives to be engaged in with a practicing physician in order to practice legally); *see, e.g.* Kelly Dunleavy, *Sacramento’s Alternative Birth Options Dwindle*, Sacramento Business Journal, October 5, 2007, available at <http://sacramento.bizjournals.com/sacramento/stories/2007/10/08/focus2.html> (last visited Feb. 14, 2009) (documenting the closing of a Sacramento birth center, which is required by law to have “supervising” agreements between doctors and midwives, and noting that no area physicians were willing to work with the closed birth center).

¹²⁵ *See, e.g.*, Dunleavy, *supra* note 124; Katherine Shaver, Birth Centers’ Closures Limit Delivery Options, THE WASHINGTON POST, May 18, 2007, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/17/AR2007051702301.html> (last visited Aug. 25, 2009) (documenting “rising malpractice insurance premiums and lagging insurance premiums” as a cause of birth center closures in the Washington-Baltimore area).

¹²⁶ WAGNER, *supra* note 4, at 133.

¹²⁷ *Id.* Unlike in freestanding alternative birth centers, “where the mother has the final say about everything that happens to her,” hospital birth centers are staffed by obstetricians whose disease oriented approach makes medication and intervention just as likely as in a normal hospital. *Id.*

¹²⁸ *See, e.g.*, Cedars-Sinai Med. Ctr., Dept of Obstetrics and Gynecology, A “Suite” Experience, www.cedars-sinai.edu/1799.html (last visited Dec. 1, 2008).

¹²⁹ As of Dec. 1, 2008, a birth suite at Cedars Sinai Medical Center in Los Angeles costs from \$1,869 to \$2,646 per day. *Id.*

¹³⁰ *Id.*

3. Maternal Information Statutes

Commentators consistently argue that empowering women is the best way to solve many maternity care problems.¹³¹ Despite this consensus, only two states are attempting to give mothers the appropriate information to make their delivery decisions by requiring that hospitals make their C-section and induction rates available to potential patients.¹³² New York requires that every hospital and birth center prepare and distribute to every prospective maternity patient, upon request, an informational leaflet explaining the treatments available.¹³³ Included in that pamphlet must be the annual C-section rates performed at the facility.¹³⁴ In contrast to the more specific requirements in New York, many states simply require that hospitals keep some records of all C-sections performed, and that these records be submitted to an appropriate agency.¹³⁵ By failing to require that specific information be made available to mothers, governments are inhibiting a mother's ability to make the best possible decision for herself and her child.¹³⁶

4. Protecting the Fetus

Much has been written about the continued expansion and recognition of fetal rights by American courts and legislatures.¹³⁷ Before the landmark case *Roe v.*

¹³¹ Donohoe, *supra* note 6 at 237-40; WAGNER, *supra* note 4, at 11, 205-208; *see, e.g.* Law, *supra* note 6, at 362 (arguing that mother's opinions ought to be given greater weight in the labor process).

¹³² BLOCK, *supra*, note 4 at 270; Donohoe, *supra* note 6 at 237; Transcript, *What to Expect: Legal Developments and Challenges in Reproductive Justice*, 15 CARDOZO J. L. GENDER 503, 513 (2009). It appears that states are making more information available to the public through the internet. *See* http://thebirthsurvey.com/dev/Results/learn_state.shtml (last visited Aug. 25, 2009) (compiling the information available for all 50 states and providing links to individual state websites). A review of state websites shows that C-section and intervention rates may be organized by county, mother's age, race, or sometimes hospital. *Id.* As helpful as this information may be, the information some hospitals may provide could be inaccurate or outdated. WAGNER, *supra* note 4, at 11, 206; *see, e.g.*, Betsy Gotbaum, *A Mother's Right to Know, New York City Hospitals Fail to Provide Legally Mandated Maternity Information*, (July 2005), available at <http://pubadvocate.nyc.gov/policy/documents/AMothersRighttoKnow.pdf>.

¹³³ N.Y. PUB. HEALTH § 2803-j (2008).

¹³⁴ N.Y. PUB. HEALTH § 2803-j (2008).

¹³⁵ *See, e.g.*, WAGNER, *supra* note 4, at 24; *see* O.C.G.A. § 31-7-280(c)(13)(C) (2009) (requiring that all hospitals operating in the state keep records of the C-section rate by number and as a percentage of deliveries, and submit those records annually to the Department of Community Health).

¹³⁶ Donohoe, *supra* note 6 at 237-39; Wagner, *supra* note 4 at 205-206.

¹³⁷ *See generally* Harris, *supra* note 86, at 139-40 (examining expanding fetal rights); Amy Lotierzo, Comment, *The Unborn Child, A Forgotten Interest: Reexamining Roe in Light of Increased Recognition of Fetal Rights*, 79 TEMP. L. REV. 279 (2006) (discussing expanding fetal rights in federal legislation, family law, tort law, property law, and family law).

Wade,¹³⁸ “[i]n areas other than criminal abortion, the law [was] reluctant to endorse any theory that life . . . begins before live birth or to accord legal rights to the unborn except in narrowly defined situations and except when the rights are contingent upon live birth.”¹³⁹ Operating off this understanding of the law’s treatment of fetal rights, the *Roe* Court reasoned that the unborn acquired legal rights only at birth.¹⁴⁰ In accordance with this rationale, *Roe* limited the state’s interest in protecting the rights of the unborn.¹⁴¹

Since *Roe*, “there has been an increasing recognition and expansion of the rights of unborn children in various areas of the law.”¹⁴² Probably the broadest protections afforded to the fetus are given by state legislatures adopting laws declaring that a fetus is a person from the time of fertilization and implantation.¹⁴³ These laws give courts the opportunity to protect the fetus or those who have a stake in its health through tort, family, and property law.¹⁴⁴ Other state protectionist laws aim to protect the fetus from criminal harms inflicted by others.¹⁴⁵ The federal government has also taken an active role in protecting the fetus from criminal harms.¹⁴⁶

¹³⁸ *Roe v. Wade*, 410 U.S. 113 (1973) (holding that unborn children are not legal persons entitled to the protections of the Constitution).

¹³⁹ *Id.* at 161.

¹⁴⁰ *Id.*

¹⁴¹ However, as others have pointed out, when the Court ruled in *Roe*, the shift to laws further recognizing the rights of the unborn had already begun. See Bradley Aron Cooper, Essay, *The Definition of “Person:” Applying the Casey Decision to Roe v. Wade*, 19 Regent U. L. Rev. 235, 241 (2006). In supporting this assertion, Mr. Cooper notes that the *Roe* Court acknowledged that some states had already begun to pass wrongful death statutes permitting parents to bring suit where prenatal injuries caused still births. *Id.*; see also *Roe*, 410 U.S. at 162. A fetus is viable when it is capable of living outside the womb. BLACK’S LAW DICTIONARY (8th ed. 2004).

¹⁴² Lotierzo, *supra* note 137, at 279.

¹⁴³ See generally 720 ILL. COMP. STAT. 5/9-1.2 (2008); LA. REV. STAT. ANN. 14:2(7) (2008) (defining “person” as human beings from the moment of fertilization and implantation); MISS. CODE ANN. § 97-3-37 (2006); MO. REV. STAT. §1.205 (2008) (declaring that the life of each human begins at conception); NEB. REV. STAT. § 30-809 (2008); TEX. PENAL CODE ANN. §1.07(a)(26) (2006). Others have suggested that there is no way to equalize the rights of the fetus and the woman without undermining a woman’s liberty interests. See generally Lisa McLennan Brown, *Symposium: The Feminism and Legal Theory Project: Celebrating Twenty Years of Feminist Pedagogy, Praxis and Prisms: Feminist Theory and the Erosion of Women’s Reproductive Rights: The Implications of Fetal Personhood Laws and In Vitro Fertilization*, 13 AM. U. J. GENDER SOC. POL’Y & L. 87, 91 (2007).

¹⁴⁴ See Lotierzo, *supra* note 137, at 279-81. These protections are not just limited to mothers, as male interests in fetal health are also recognized. See *Farley v. Sartin*, 466 S.E. 2d 522 (W. Va. 1995) (permitting bereaved father to bring a cause of action under West Virginia’s wrongful death statute for the death of his wife and her nonviable fetus).

¹⁴⁵ Currently, thirty-five states have passed legislation recognizing that, in some circumstances, the unlawful killing of an unborn child is a homicide. See National Right to Life Committee, *State Unborn Victim Laws*, available at http://www.nrlc.org/Unborn_Victims/Statehomicidelaws092302.html (last visited Jan. 29, 2009). It merits mentioning that New York’s statutes are conflicting. Under New York statutory law, the

More unsettling than the above protections are those policies that aim to protect the fetus from harms that have not yet occurred.¹⁴⁷ Under the auspices of enforcing the state's interest in protecting fetal health, courts have forced mothers to undergo C-sections¹⁴⁸ and have used "incarceration, detention, orders of hospital confinement, and threats thereof, to compel pregnant women to access prenatal care and to submit to their physicians' directions regarding medical treatment for the benefit of fetal health."¹⁴⁹ Judges have also used such threats to "encourage" the mother to bring her fetus to term.¹⁵⁰

i. Compelled Medical Treatment

The right to refuse medical treatment is not absolute,¹⁵¹ and where a mother refuses to undergo medical treatment, some courts have performed a balancing test to decide whether a compelling state interest exists to override the competent mother's refusal of medical treatment.¹⁵² Where the judge has determined that the state's interests outweigh the mother's right of bodily autonomy, a court will subvert maternal rights to protect the fetus.¹⁵³ Although only a few forced medication cases have ever occurred, it is plausible that changes in how women are perceiving birth

killing of an "unborn child" after twenty-four weeks of pregnancy is homicide. N.Y. Pen. Law § 125.00 (McKinney 1998). But under a separate statutory provision, a "person" that is the victim of a homicide is statutorily defined as a "human being who has been born and is alive." N.Y. Pen. Law § 125.05 (McKinney 1998). See *People v. Joseph*, 130 Misc. 2d 377, 496 N.Y.S.2d 328 (County Court 1985); *In re Gloria C.*, 124 Misc.2d 313, 476 N.Y.S.2d 991 (N.Y. Fam. Ct. 1984); *People v. Vercelletto*, 514 N.Y.S.2d 177 (Co. Ct. 1987).

¹⁴⁶ See Unborn Victims of Violence Act, 18 U.S.C.S. §1841 (LexisNexis 2008) (protecting the unborn fetus by punishing those who cause criminal injury to a child in utero).

¹⁴⁷ Cf. Cherry, *supra* note 113.

¹⁴⁸ See *In Re A.C.*, 533 A.2d 611 (D.C. 1987) (forcing terminally ill cancer patient to undergo C-section); *Jefferson*, 274 S.E.2d at 457 (affirming lower court order compelling a woman to submit to C-section and other procedures allegedly necessary to save the fetus's life); *Pemberton*, 66 F. Supp.2d at 1247 (discussed below).

¹⁴⁹ Cherry, *supra* note 113, at 148.

¹⁵⁰ *Id.*

¹⁵¹ *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 280- 82 (1990).

¹⁵² See Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At The Intersection Of The Ideology Of Motherhood, The Practice Of Defaulting to Science, And The Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205 1252-53 (1992) (discussing the balancing test used in compelled medical treatment cases).

¹⁵³ The likelihood that such a petition will be granted is unclear. Numerous commentators have argued that such court orders are unacceptable. See generally *Harris*, *supra* note 86, at 161; *Cohan*, *supra* note 112, at 896 n.213 (highlighting multiple law review articles that discuss the maternal fetal rights debate); but see Daniel R. Leavy, *The Maternal-Fetal Conflict: The Right of a Woman to Refuse A Cesarean Section Versus The State's Interest In Saving The Life of The Fetus*, 108 W. VA. L. REV. 97, 98-99 (2005) (arguing that a state should be able to require a woman to undergo a C-section based on a duty to rescue due to the special relationship formed between the mother and fetus by the time of viability).

(most dramatically represented by the home birth movement), will give rise to more situations where the judiciary will be called upon to resolve delivery decisions.¹⁵⁴

In *Pemberton v. Tallahassee Mem'l. Reg. Med. Ctr., Inc.*, Florida's Second Judicial Circuit granted permission to Tallahassee Memorial Medical Center to forcibly perform a C-section on Laura Pemberton because attempting vaginal delivery constituted too great a risk to fetal health, given her physical condition.¹⁵⁵ The scar from Ms. Pemberton's previous C-section posed such a threat to her unborn child's life that no doctor or midwife would attend a vaginal delivery.¹⁵⁶ Yet, Ms. Pemberton remained convinced that vaginal delivery was the safest way to deliver her child.¹⁵⁷ Ms. Pemberton ignored all medical advice and ordered medical supplies so that she and her husband could deliver their child alone.¹⁵⁸ After laboring for two days, Ms. Pemberton checked into Tallahassee Memorial requesting IV fluids.¹⁵⁹ While at Tallahassee Memorial, three separate physicians determined that a cesarean was medically necessary.¹⁶⁰ Rather than undergoing a C-section, Ms. Pemberton fled Tallahassee Memorial.¹⁶¹ That decision resulted in police forcibly returning Ms. Pemberton to Tallahassee Memorial, where doctors proceeded to forcibly execute a C-section after determining that the state's interest in delivering a healthy baby superseded Ms. Pemberton's interest in refusing a C-section.¹⁶²

Ms. Pemberton's case is often cited as an example of the government overstepping its bounds and hospitals refusing to let birth proceed naturally.¹⁶³ But in light of the government's propensity to protect the fetus from harm, it also provides a warning sign to mothers participating in home births. Like Ms. Pemberton, many mothers that decide to forego hospital births have done so based on strong personal beliefs about childbirth.¹⁶⁴ As the home birth movement and the reaction against medicalized birth grow in popularity, mothers will continue place greater faith in their body's natural ability to deliver safely. As anti-intervention convictions grow stronger, more circumstances may arise where doctor and patient

¹⁵⁴ See *infra* part IV; Cf. Leavy, *supra* note 153.

¹⁵⁵ Pemberton, 66 F. Supp.2d at 1256.

¹⁵⁶ Ms. Pemberton's scar "extended well beyond the traditional low vertical incision up into the thickened myometrium." *Id.* at 1249. Initially, a physician did support a vaginal birth, but the physician withdrew his support when Ms. Pemberton was twenty-five weeks pregnant. BLOCK, *supra* note 4, at 249. The court's opinion differs from Block's account in that it does mention that a midwife was attending during the labor. Pemberton, 66 F. Supp.2d at 1249.

¹⁵⁷ BLOCK, *supra* note 4, at 249.

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

¹⁶⁰ Pemberton, 66 F. Supp. 2d at 1249. All tests, indicated that the fetus was healthy and birth was progressing safely, albeit slowly. BLOCK, *supra* note 4, at 251.

¹⁶¹ BLOCK, *supra* note 4, at 250.

¹⁶² Pemberton, 66 F. Supp. 2d at 1248.

¹⁶³ BLOCK, *supra* note 4, at 250.

¹⁶⁴ See Cohen, *supra* note 21, at 855-57.

strongly disagree about the appropriate delivery method. More disagreements could lead to court compelled medical treatment.¹⁶⁵

ii. Detention, Incarceration, and Child Abuse

Courts may also take a mother into custody to protect the fetus from potential harm. Professor Cherry explains that some courts may use their *parens patriae*¹⁶⁶ power to take mothers into custody and “compel state-sanctioned maternal behavior deemed necessary for the health or life of fetuses.”¹⁶⁷ Some courts have relied on provisions in state child welfare laws to support taking custody of the fetus.¹⁶⁸ Others have taken an aggressive role in fetal protection where there exists a high potential that fetal harms will arise from poor maternal choices.¹⁶⁹ This is especially true where a woman’s criminal actions have put fetal health at risk.¹⁷⁰ Implicit in these policies is a belief that alcohol or drug dependent mothers are unfit to make decisions about what is best for the life and well being of their fetuses.¹⁷¹

The judiciary’s distrust of maternal decision-making in some circumstances and its willingness to enforce child abuse statutes against drug dependent mothers could begin to affect mothers who simply possess anti-intervention convictions. At least one trial court has determined that a mother’s refusal to consent to a C-section was a “major consideration” when terminating a mother’s parental rights.¹⁷² In that case,

¹⁶⁵ Because the government has taken a greater role in protecting the fetus, and decisions may have to be made in an instant, it is possible that the courts will determine that compelled medical treatment is acceptable. *See infra* Part IV.

¹⁶⁶The state regarded as a sovereign; the state in its capacity as provider of protection to those unable to care for themselves. BLACK’S LAW DICTIONARY (8th ed. 2004).

¹⁶⁷Cherry, *supra* note 113, at 159.

¹⁶⁸*See Wisconsin ex rel Angela M.W. v. Kruziki*, 561 N.W. 2d. 729 (Wis. 1997).

¹⁶⁹Mothers have faced murder and child endangerment charges for using drugs while pregnant. *See State v. McKnight*, 576 S.E.2d 168 (convicting mother of murder after it was shown that mother’s use of cocaine caused fetal death); *Whitner v. South Carolina*, 492 S.E.2d 777 (1997), *cert denied*, 523 U.S. 1145 (1998) (charging mother with child endangerment after child tested positive for cocaine after birth); *Grodin v. Grodin*, 301 N.W.2d 869, 870 (Mich. Ct. App 1980) (allowing child to sue mother for taking drug during pregnancy that may have caused the child’s teeth discoloration); *Curlender v. Bio-Science Labs.*, 165 Cal. Rptr. 477, 488 (1980); *See generally* Cherry, *supra* note 113 (discussing the detention and confinement of pregnant women for the sake of fetal health); Brown, *supra* note 143, at 91.

¹⁷⁰Courts in more than thirty states have heard attempts to prosecute women for using drugs or alcohol during pregnancy. SHEENA MEREDITH, *POLICING PREGNANCY, THE LAW AND ETHICS OF OBSTETRIC CONFLICT* 78 (Ashgate 2005) (citing to Cynthia Cooper, Ford Foundation Report, *Pregnant and Punished*, available at <http://www.fordfound.org/publications>).

¹⁷¹Cherry, *supra* note 113, at 152-53.

¹⁷² *See New Jersey Div. of Youth & Fam. Servs. v. V.M. and B.G.*, 408 N.J. Super 222, 249 (2009) (Carchman, J. Concurring). In affirming the trial court’s approval of the New Jersey Division of Youth and Family Services plan for termination of parental rights, the per curium opinion declined to decide the issue of whether refusal to consent to a C-section can be considered an element of abuse and neglect because “substantial additional evidence of abuse and neglect supported the ultimate findings.” *Id.* at 224.

the mother's combative behavior during labor (including thrashing, screaming and refusing to consent to a C-section or fetal scalp stimulation) resulted in an emergency competency evaluation.¹⁷³ Following an initial conclusion that she had the capacity for informed consent with regard to the C-section, the mother successfully delivered vaginally without incident.¹⁷⁴ Subsequent investigations into the mother's mental state and her actions during those investigations resulted in termination of her parental rights based upon New Jersey's child abuse and neglect statute.¹⁷⁵ Court decisions like this will affect maternal decision-making.¹⁷⁶

D. Limits During Labor

Delivering a baby is dangerous. A relatively mundane delivery can transform into an outright emergency in an instant.¹⁷⁷ Add a team of nurses awaiting instruction, labor pains, and general excitement to an already hectic environment and it is easy to see why the physician needs to play an authoritative role in the delivery room. Fairly or unfairly, this authority makes mothers vulnerable to coercion.¹⁷⁸ Because a physician has economic, legal, and personal interests in how a child is delivered, much of the criticism levied against the current maternity care system surrounds how this authority affects delivery outcomes.¹⁷⁹ The solutions offered within this Note presume that such criticisms have merit.¹⁸⁰

¹⁷³ *Id.* at 227-28.

¹⁷⁴ *Id.* at 228.

¹⁷⁵ *Id.* at 224. Although the mother's actions after delivery may justify the court's decision, her parental rights may not have been threatened had she consented to the C-section. *See, e.g. id.* at 228-34.

¹⁷⁶ By refusing to consent to a C-section or other procedures, mothers may be subject to unnecessary mental health examinations, or their refusal could weigh against their favor in a future parental rights dispute. Perhaps more pervasive than these hypothetical circumstances is the chilling effect that court decisions like *V.M.* will have on maternal choice; as they could result in maternal submission to unwanted medical treatment for fear of similar adverse consequences. From an alternative perspective, decisions like *V.M.* also provide aggressive advocates within the home birth movement with another opportunity to demonize mainstream medical care. *See infra* Part IV.E. Such demonization could contribute to a hostile relationship between patient and physician.

¹⁷⁷ *Cf.* Heyman, *supra* note 50.

¹⁷⁸ *See generally* BLOCK, *supra* note 4, at 261; WAGNER, *supra* note 4, at 130-32.

¹⁷⁹ The following section is a summation of a major criticism levied against physicians. *See* WAGNER, *supra* note 4; BLOCK, *supra* note 4, at 17, 42, 45-55; Hermer, *supra* note 16. The author does not suggest that these criticisms are completely correct or applicable to all doctors; however, considering the amount of attention the subject has received from the popular media as well as academic sources, the author believes that presenting the criticism to the reader to demonstrate the ways that a mother may have her choice limited is warranted.

¹⁸⁰ At least some evidence suggests that mothers may be pressured into having C-sections. *See* Law, *supra* note 6, at 354 (citing a 2006 "Listening to Mothers" survey finding that almost 10% of women surveyed reported feeling pressured to have a C-section); BLOCK, *supra* note 4, at 17 (noting that a 2005 survey reported that one in ten women reported being pressured to induce).

1. Pushed Births

More than ever before, mothers are having C-sections and receiving medical assistance when delivering their children.¹⁸¹ Medical malpractice law undoubtedly contributes to this environment of intervention. “Obstetricians and gynecologists have historically been targets of lawsuits more often than other physicians. ... [They] are more likely than any other kind of physician to lose a malpractice trial— and they pay correspondingly high insurance premiums.”¹⁸² Physicians are well aware of this and this knowledge may influence their chosen treatment methods.¹⁸³

Performing C-sections provides an opportunity to protect against lawsuits.¹⁸⁴ In general, malpractice suits concerning C-sections focus on two types of negligence allegations: failure to perform a necessary C-section and negligent performance of a C-section.¹⁸⁵ Choosing to perform a C-section allows a physician to avoid the potential liabilities that may arise from a “failure to perform a necessary C-section” suit¹⁸⁶ and permits them to complete the procedure in non-emergency situation, which lowers the likelihood that harm will occur.¹⁸⁷ In many circumstances, C-sections are just as safe,¹⁸⁸ and can be performed in a much shorter time than vaginal childbirth.¹⁸⁹ C-sections, therefore, arguably allow a physician to maximize the efficiency and profitability of his or her practice without compromising maternal or fetal health.

¹⁸¹ The C-section rate reached an all time high in 2007. *See supra* note 70. The rate of labor induction more than doubled from 1990 to 1998, jumping to nineteen and four-tenths percent of all births in 1998. Linda Villarosa, *Making an Appointment With the Stork*, N.Y. TIMES, June 23, 2002 available at <http://query.nytimes.com> (archived). Currently fifteen percent of deliveries in American are aided by induction methods. American College of Obstetricians and Gynecologists, *supra* note 77.

¹⁸² James Gibson, *Doctrinal Feedback and (Un) Reasonable Care*, 94 VA. L. REV. 1641, 1673 (2008) (internal citations omitted).

¹⁸³ Gibson, *supra* note 182, at 1674 (citing to Russell Localio et al., *Relationship Between Malpractice Claims and Cesarean Delivery*, 269 JAMA 366 (1993); Sheldon Brown III, *Lawsuit Activity, Defensive Medicine and Small Area Variation: The Case of Cesarean Sections Revisited*, 2 HEALTH ECON. POL’Y & L. 285 (2007)). Dr. Wagner suggests this conclusion as well. *See* WAGNER, *supra* note 4, at 154. Professor Law notes that others have suggested that physician fears surrounding malpractice liability may be exaggerated. Law, *supra* note 6, at 370 (citing to Margaret Lent, *The Medical and Legal Risks of Electronic Fetal Monitoring*, 51 STAN. L. REV. 897, 816-17).

¹⁸⁴ Gibson, *supra* note 182, at 1674 (documenting that a “substantial majority” of obstetricians respond to the legal exposure by increasing the number of cesarean deliveries they perform).

¹⁸⁵ Hilary E. Berkman, *A Discussion of Medical Malpractice and Cesarean Section*, 70 ORE. L. R. 629 (1991) (identifying and discussing both malpractice claims).

¹⁸⁶ *Id.*

¹⁸⁷ WAGNER, *supra* note 4, at 41.

¹⁸⁸ *See supra* note 72.

¹⁸⁹ WAGNER, *supra* note 4, at 38.

But what could be interpreted as physicians opting to provide one of two “equally reasonable alternatives,”¹⁹⁰ others suggest is demonstrative of a more disturbing trend.¹⁹¹ In addition to the factors Professor Sylvia A. Law identifies as contributing to the high C-section rate, critics argue that doctors are allowing the desired outcome of a quick, cost-effective, and liability free delivery, instead of medical necessity, determine how laboring mothers will deliver their children.¹⁹² Too often, these critics allege, doctors will use their disproportionate power to “push” their patients into undergoing unnecessary procedures¹⁹³ or taking unnecessary medication without giving proper respect to the mother’s wishes or her body’s natural ability to safely deliver a child.¹⁹⁴

Reducing the risk of malpractice liability is not the only reason that critics suggest a push may occur. Others propose that certain personal factors also contribute to physicians ignoring the medical evidence and coercing mothers into undergoing intrusive and unnecessary procedures.¹⁹⁵ For example, less time is required for a C-section, thereby freeing up more time for other activities, such as sleeping (nighttime delivery) or increasing income by seeing other patients.¹⁹⁶ Dr.

¹⁹⁰ Law, *supra* note 6, at 362. This Note agrees with Professor Law that “the voices of women should be given greater weight, particularly in circumstances such as those . . . where professional opinion is in conflict and women bring different values to the birthing experience.” *Id.*

¹⁹¹ Professor Law concisely summarizes four factors contributing to unnecessary and unwanted C-sections: namely Electronic Fetal Monitoring, C-section for breech birth, failure to progress, and vaginal birth after C-section. *See id.* at 354-62.

¹⁹² WAGNER, *supra* note 4, at 39-41.

¹⁹³ Perhaps the most extreme example of this “push” can be seen in the instance of vaginal birth after C-section (hereinafter “VBAC”). More than 9 out of 10 births after an initial C-section are also C-sections. Pamela Paul, *The Trouble With Repeat Cesareans*, TIME, Feb. 19, 2009, available at <http://www.time.com/printout/0,8816,1880665,00.html> (last visited Aug. 27, 2009). Many of these C-sections may not be the result of maternal choice, but are instead a consequence of physicians and hospitals refusing to attend VBAC deliveries. *Id.*; Law, *supra* note 6, at 357-60, 368 (explaining that the VBAC ban in many hospitals stems from a “misunderstanding of the law”). Others have documented that to protect against possible liability from attending such deliveries, doctors may be providing skewed information to mothers about the safety of VBACs. *See* Paul, *supra* note 193. Physicians may be “pushing” mothers towards intervention for other reasons as well. WAGNER, *supra* note 4, at 95-96. For example, a baby may be deemed “too big” or may remain in the uterus too long. *Id.*

¹⁹⁴ WAGNER, *supra* note 4, at 39. Whatever the cause, some critics point to federal studies analyzing birth certificates to give merit to their claim. *Id.* (citing to Ctrs. For Disease Control & Prevention, Nat’l Vital Stats. Reports, Births: Method of Delivery, available at www.cdc.gov/nchs/birth (last visited Dec. 4, 2008). The certificates show that the percentage of births and emergency C-sections that happen Monday through Friday between nine and five is rapidly increasing relative to weekends and nighttime hours. *Id.* Wagner suggests that this evidence indicates that physicians are influencing the time of delivery so they will not be inconvenienced by having to work beyond typical working hours. *Id.* at 29, 27.

¹⁹⁵ WAGNER, *supra* note 4, at 40-41.

¹⁹⁶ *Id.* at 38-41.

Marsden Wagner¹⁹⁷ argues that other contributing factors include: a desire to control the most unpredictable portion of professional life, a belief in the trustworthiness of machines over a woman's understanding of her own body, and a need to look for problems when none exist.¹⁹⁸ Lastly, Dr. Wagner asserts that doctors may perform procedures as a means to solidify their importance within a medical community that is beginning to recognize the utility of delivering with a midwife.¹⁹⁹

Regardless of the validity of these criticisms, they will not be disappearing in the near future. The factors indicating that a C-section is necessary are not based on objective criteria;²⁰⁰ instead, physicians must rely on their own judgment when determining whether a C-section is warranted.²⁰¹ So long as the economic, legal, and personal motivations continue to exist, so too will the criticisms about physician motivations for intervening with natural labor. As these criticisms intensify in the mainstream media,²⁰² and the reaction against such intervention tactics becomes stronger,²⁰³ the number of physician-patient conflicts may grow more frequent, and could produce undesirable results.

2. Informed Consent

Physicians may be making improper promises or inadequate disclosures regarding the dangers of C-sections and inductions.²⁰⁴ In a recent study, less than one-third of the women surveyed after delivery were familiar with the risks posed by C-sections.²⁰⁵ That same study showed that less than half the women surveyed could correctly identify the risks of induction.²⁰⁶ The doctrine of informed consent explains that:

Every human being of adult years and sound mind has the right to determine what shall be done with [their] own body; and a surgeon who performs an operation without [their] patient's consent commits an assault, for which he is liable in damages . . . This is true except in cases of

¹⁹⁷ Dr. Wagner is a former director of Women's and Children's Health at the World Health Organization. *Id.* at viii-ix.

¹⁹⁸ *Id.* at 38-41.

¹⁹⁹ *Id.* at 39.

²⁰⁰ MEREDITH, *supra* note 169, at 71 *Cf.* Paul, *supra* note 193.

²⁰¹ MEREDITH, *supra* note 169, at 71; *Cf.* Paul, *supra* note 193.

²⁰² *See infra* part IV.C.5.

²⁰³ *Cf.* BLOCK, *supra* note 4 at 262 (documenting "informed dissent" and teaching women the concept of saying "no" to interventions).

²⁰⁴ *Cf.* MEREDITH, *supra* note 169, at 71; WAGNER, *supra* note 4, at 45 (asserting that "the fact that women are choosing C-sections strongly suggests they are not being told the truth about all the risks to themselves and to their babies"); Paul, *supra* note 193.

²⁰⁵ BLOCK, *supra* note 4, at 153-54.

²⁰⁶ *Id.* at 154.

emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.²⁰⁷

If women cannot identify the risks associated with a procedure, their consent may not be truly informed.²⁰⁸

What exactly a physician must disclose varies significantly from jurisdiction to jurisdiction.²⁰⁹ Roughly half of the jurisdictions in America require a physician to provide information that a "reasonable medical practitioner" would provide in the same or similar circumstances.²¹⁰ The remaining U.S. jurisdictions have abandoned this standard in favor of a "reasonable patient" standard,²¹¹ which requires the physician, on the basis of his medical training and experience, to objectively disclose what a reasonable patient expectably would deem material in making her decision.²¹² In obtaining a mother's informed consent, a physician may be able to comply with informed consent standards while papering over risks that may concern reasonable mothers.²¹³

Even if an individual physician does not believe that C-sections or inductions have a great potential for harm, the risks must still be clearly conveyed to mothers when making decisions. Because "[a] compelled surgical intrusion into an individual's body . . . implicates expectations of privacy and security" of great magnitude,²¹⁴ it is paramount that a physician comply with the requirements of informed consent before performing a C-section. Informing a mother of these risks may change her feelings towards undergoing a C-section or induction.²¹⁵

There are also disagreements about the relative benefits and dangers posed by induced labor. Physicians differ in their opinions regarding how dangerous Oxytocin is and exactly how cautious a doctor should be before administering it.²¹⁶ A

²⁰⁷ *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129-30 (N.Y. 1914).

²⁰⁸ Only seventeen percent of women who received an episiotomy reported having a choice in the matter. BLOCK, *supra* note 4, at 154. An episiotomy is a surgical incision used to enlarge the vaginal opening to help deliver the baby. American Pregnancy Association, *Episiotomy*, available at <http://www.americanpregnancy.org/labornbirth/episiotomy.html> (last accessed Jan. 30 2009).

²⁰⁹ Ketler, *supra* note 3, at 1045 (citing to Richard A. Heinemann, Note, *Pushing to the Limits of Informed Consent: Johnson v. Kokemoor and Physician-Specific Disclosure*, 1997 WIS. L. REV. 1079, 1082(1997)).

²¹⁰ *Id.*

²¹¹ *Id.*

²¹² *See Canterbury v. Spence*, 464 F.2d 772 (D. C. Cir. 1972).

²¹³ BLOCK, *supra* note 4, at 165, 253, 257.

²¹⁴ *Sell v. United States*, 539 U.S. 166, 176 (2005) (citing to *Riggins v. Nevada*, 504 U.S. 124 (1992)).

²¹⁵ Dr. Wagner suggests that mothers who elect to have a C-section without a medical reason do not have an understanding of the risks inherent in the procedure. *See* WAGNER, *supra* note 4, at 45. Professor Law notes that the medical profession has done a commendable job of attempting to reduce the appearance of coercion by requiring that doctors only discuss the possibility of elective C-sections after mother raises the issue. Law, *supra* note 6, at 367.

²¹⁶ 1 Am. Jur. 3d *Proof of Facts* 1.

fundamental question deals with how rapidly the starting dose should be increased when the patient fails to respond.²¹⁷ Oxytocin has been administered under circumstances that later proved to be inappropriate, resulting in asphyxiation of the fetus, severe neurological damage to the baby, mental retardation, and a general lack of motor function and coordination.²¹⁸ Furthermore, inducing birth does not always work²¹⁹ and a C-section may still be required.²²⁰

Induction also presents a unique problem that physicians may not make known to their patients. This threat is known as the cascade of intervention.²²¹ Pitocin produces stronger and more frequent contractions.²²² Once the induction process begins, these stronger and more frequent contractions cause pain in the increasingly sensitive uterus.²²³ Because the contractions are more painful, more anesthetics are required.²²⁴ As more anesthetics are required, additional medications are required to combat the side effects of those medications.²²⁵ A mother may not appreciate the pain that comes along with induced labor. If she is made aware of the possibility that additional medications may be needed, she may not exercise this option.

Lastly, it has also been suggested that some courts have wrongfully assumed that the “elevated level of anxiety that laboring patients experience renders unnecessary and even harmful the usual requirements of informed consent, because in their state of anxiety, laboring patients are unable to make the rational choices that are a key reason for obtaining informed consent in the first place.”²²⁶ Dr. Suzanne K. Ketler further identified that some courts have subscribed to the idea that labor and birth are a process that happen without choice or decision, and consequently informed consent is not required.²²⁷

However, informed consent law in the labor and delivery sphere continues to evolve. As Dr. Ketler highlighted, *Schreiber v. Physicians Ins. Co. of Wisconsin*²²⁸

²¹⁷ 1 Am. Jur. 3d *Proof of Facts* 1 (citing to GABBE, *supra* note 78; J. Seitchik et al., Amniotomy and Oxytocin Treatment of Functional Dystocia and Route of Delivery, 155 AM. J. OF OBSTETRICS AND GYNECOLOGY 585, 592 (1986)).

²¹⁸ 1 Am. Jur. 3d *Proof of Facts* 1 (citing *Low v. United States*, 795 F.3d 466 (5th Cir. 1996)); *Moore v. Grandview Hospital*, 495 N.E.2d 934 (Ohio 1986)).

²¹⁹ If a mother’s water breaks but her cervix fails to dilate despite receiving the drugs containing prostaglandins, she probably will need a c-section due to the risk of infection. 1 Am. Jur. 3d *Proof of Facts* 1.

²²⁰ WAGNER, *supra* note 4, 78-79.

²²¹ BLOCK, *supra* note 4, at 139.

²²² *Id.*

²²³ *Id.* Each medication carries with it its own side effect and own risks. *Id.*

²²⁴ Hermer, *supra* note 16, at 348.

²²⁵ BLOCK, *supra* note 4, at 139-40.

²²⁶ Ketler, *supra* note 3, at 1045.

²²⁷ *Id.* at 1040-44.

²²⁸ 588 N.W.2d 26 (Wis. 1999) (finding a breach of statutory duty to conduct second informed consent discussion with patient who revoked consent to vaginal delivery and requested C-section).

changed the process and timing of informed consent to a more patient centered approach.²²⁹ Rather than end with a physician's specific disclosure, Dr. Ketler notes that *Schreiber* essentially requires physicians to conduct ongoing informed consent discussions with laboring patients whenever there is a "substantial change in circumstance, either medical or legal."²³⁰ This approach is not without its ambiguities or shortcomings,²³¹ but in light of the criticisms levied against the medical profession,²³² applying this standard could curb criticisms of physician coercion and potentially foster a more cooperative doctor-patient relationship.²³³

E. Aggressive Advocates

Arguments for home births and midwifery can be quite persuasive.²³⁴ In addition to voicing the benefits of vaginal birth with a midwife, advocates are quick to criticize physicians, hospitals, and the practices used within.²³⁵ Home birth proponents often draw a stark contrast between the soothing environment that a mother can create when she decides to give birth at home and the sterile, sometimes harsh, hospital environment.²³⁶ In espousing an aggressive, anti-physician position, these advocates may be guiding some mothers towards making unsafe birth choices.

Midwife and home birth advocacy resources often cite to personal stories of women who, having opted for hospital births, lost control of the entire process before undergoing what they believed were unnecessary C-sections or other needless procedures.²³⁷ These advocates allege that home birth promises a more rewarding

²²⁹ Ketler, *supra* note 3, at 1031.

²³⁰ *Id.* at 1053.

²³¹ *Id.* at 1054-56. Dr. Ketler notes that this process "encroaches . . . on the physicians' decision making ability and fails to provide physicians with reasonable guidelines for making medically necessary decisions . . ." *Id.* at 1032. Moreover, Dr. Ketler criticizes the process as resulting in treatment on demand. *Id.* at 1052. Dr. Ketler proposes that statutory amendments be enacted to clarify when such additional discussions are needed. *Id.* at 1055. The author agrees with this recommendation and believes that such changes ought to be clearly delineated and then taught to mothers through the patient education process suggested by this Note. *See infra* part V.

²³² *See* Part III.D (outlining physician coercion).

²³³ Although Dr. Ketler cautions that adopting this standard would contribute to the physician's decreasing professional autonomy, a more patient centered approach could facilitate better communication and consequently result in more effective care.

²³⁴ *See generally* WAGNER, *supra* note 4; BLOCK, *supra* note 4. There is even a national campaign aggressively advocating for uniform regulation and licensure for Direct-Entry Midwives. *See* The Big Push For Midwives, www.thebigpushformidwives.org (last visited Dec. 2, 2008).

²³⁵ *Cf.* WAGNER, *supra* note 4, at 20-27 (criticizing the "tribal" culture of the hospital setting and suggesting that some doctors have a desire to harm women).

²³⁶ *Id.*

²³⁷ BLOCK, *supra* note 4, at 45-70.

delivery experience.²³⁸ There are many health benefits to delivering vaginally.²³⁹ In addition to explaining those benefits, some advocates go further, encouraging home births because natural childbirth may increase the likelihood that a woman will receive a “love cocktail” of chemicals released by the body during labor.²⁴⁰ Such a chemical rush, they posit, forges a stronger, deeper bond between mother and child.²⁴¹

Amidst these promises of a more fulfilling delivery and encouragement for mothers to trust their bodies’ natural abilities to correct minor pregnancy problems, most midwifery proponents openly admit that the option is not safe for every mother.²⁴² However, strong advocacy for the many positives of “natural” delivery may dilute warnings regarding the safety risks involved in childbirth and could potentially lull mothers or midwives into a false sense of confidence regarding the likelihood that a safe delivery will ensue.²⁴³

These critics, justified or not, also lobby harsh criticisms about the utility, motives, and qualifications of the mainstream medical community.²⁴⁴ They paint hospitals as sterile, cold, environments, run by a “tribe” of inhuman physicians who are brainwashed into believing that patient choice is subordinate to convenience and financial well-being.²⁴⁵ Such characterizations are unfair and can foster a combative

²³⁸ Some share stories of having orgasms while giving birth, and claim that other mothers can have similar experiences (not necessarily an actual orgasm, but a similar happy conclusion to labor). See Juju Chang and Gail Deutsch, *Labor Orgasms Called ‘Best-Kept Secret,’* ABC NEWS, Dec. 9, 2008, available at <http://i.abcnews.com/Health/Story?id=6120045&page=2> (last visited Aug. 26, 2009),

²³⁹ See Law, *supra* note 6, at 350.

²⁴⁰ See THE BUSINESS OF BEING BORN, *supra* note 34.

²⁴¹ *Id.*

²⁴² BLOCK, *supra* note 4, at 95, 264; WAGNER, *supra* note 4, at 35, 195; Hermer, *supra* note 4, at 344.

²⁴³ At least some parents that are selecting home births underestimate the potential risk involved. Wolfson, *supra* note 87. There are numerous reported examples of women in the medically high-risk category who have opted for home birth. *Id.* A mother’s strong desire to deliver outside the hospital, coupled with a trust in the body’s capability to deliver safely, could result in high-risk mothers delivering outside the hospital. When that confidence is supported by a midwife, who may attend labors that others consider “too risky” due to an error in judgment regarding the “screen-out” process or the consequences of the economic pressures inherent in maintaining a viable midwifery practice (high malpractice premiums, low-usage, etc.), the result could be that dangerous deliveries are attempted outside the safety of the hospital setting. Cf. Dunleavy, *supra* note 124 (highlighting the economic difficulties of maintaining a viable midwife practice). Admittedly, such a choice is each mother’s to make, but when the decision is influenced by a demonization of mainstream medical practices, the perception that a hospital birth is robbing the mother of one of life’s most fulfilling experiences, and that such a choice could result in a weaker connection between mother and child, mothers may be improperly pushed towards taking an unnecessary risk.

²⁴⁴ See Craig J. Thompson, *Consumer Risk Perceptions in a Community of Reflexive Doubt*, 32 J. CONSUMER RESEARCH 235, 236-48.

²⁴⁵ WAGNER, *supra* note 4, 13-36. Dr. Wagner and others openly admit that such generalizations do not apply to all physicians. See *id.* at 42; BLOCK, *supra* note 4, at 264.

relationship between doctor and patient.²⁴⁶ As these criticisms become well known through the mainstream media²⁴⁷ there may be an increase in patient refusal to consent to physician-recommended procedures.²⁴⁸

The alternative birth movement is not alone in using the media to warn against the dangers presented by other birth choices. The medical community is frequently criticized for everything from ignoring scientific facts regarding the safety of midwifery & home births,²⁴⁹ to employing scare tactics to control doctors and hospitals.²⁵⁰ The medical lobby's media use not only affects individual mother's delivery decisions, but also plays a major role in influencing the legality of midwifery.²⁵¹

Taken together, the aggressive advocates on both sides of the debate have created an environment where determining what constitutes a safe delivery choice is a challenging task. The home birth movement plays upon strong emotional desires for a satisfying delivery outside the hospital, a sense of empowerment, and a distrust of physicians to create strong willed mothers who may not easily submit to necessary medical intervention. On the other side of the spectrum, mothers who afford too much weight to the medical lobby's distrust of out of hospital births are at risk for experiencing needless medical interventions because they choose to deliver in a hospital, rather than another available locale.²⁵²

²⁴⁶ When emergencies require obstetrical intervention, such a relationship can jeopardize maternal or fetal health.

²⁴⁷ See *supra* note 34.

²⁴⁸ Cf. BLOCK, *supra* note 4, at 262 (documenting the "informed dissent" process, teaching women to say no to electronic fetal monitoring, induced labor, etc.). Ultimately, if such knowledge grows more common, the result could be more court ordered medication or termination of parental rights. Cf. Cohen, *supra* note 21, at 861 (explaining the idea that there has begun to be a turn on the nation's long, unquestioning deference to doctors, and noting that some have begun to realize that decisions that women have turned over to doctors must be reclaimed because they directly affect personal dignity and definitions of self).

²⁴⁹ See WAGNER, *supra* note 4, at 45, 150-51.

²⁵⁰ *Id.* at 27, 150.

²⁵¹ *Id.* at 35, 118-19, 124 (documenting mainstream medical associations' actions at legislative hearings considering legalizing Direct-Entry Midwifery); Cohen, *supra* note 21, at 854 (documenting that a standard explanation for the stalemate on midwifery reform is the medical lobby's attempt to "preserve its economic share of the birthing business by preventing midwifery regulation and utilizing its traditional influence over courts.").

²⁵² These complications demonstrate the need for an educational source that will offer non-biased information to expecting mothers. This Note is not alone in suggesting that increased maternal education is necessary to improve maternity care in America. See WAGNER, *supra* note 4, at 207-09; Donohoe, *supra* note 6, at 230 ("only through information and education will women be able to create market forces that will slow the cesarean epidemic"). Part V will propose that maternal education be provided by a disinterested collection of midwives & physicians who can evaluate each mother's unique risks and explain the benefits of each delivery option.

F. Insurers Limiting Choice

For some women, a harsh reality of childbirth is that their insurance coverage may limit the options they have in delivering their child. “A woman who selects a mode of delivery based on what she is told her insurance will reimburse is not exercising choice based on the best interests of her child and self.”²⁵³ Mothers who wish to have their delivery attended by a midwife may have trouble obtaining coverage for the procedure. Although the Federal Government has rewritten its insurance plans to allow midwives to be paid,²⁵⁴ some insurance companies do not cover home births,²⁵⁵ and not all state Medicaid programs reimburse Direct-Entry Midwives.²⁵⁶ Additionally, recent cost-cutting efforts have precluded some mothers who receive Medicaid from delivering in freestanding alternative birth centers.²⁵⁷ On the caregiver side, high malpractice insurance premiums cause physicians and hospitals to refuse to admit mothers with previous C-sections to attempt vaginal deliveries,²⁵⁸ discourage physicians from providing legally required backup services

²⁵³ Law, *supra* note 6, at 376.

²⁵⁴ See 10 U.S.C. § 1079 (a)(13) (Amended in 1990, *see* P.L. 101-510, 104 Stat. 1581) (including midwifery as a covered medical care for the armed forces) and 42 U.S.C.A. §1396d (a)(17) (2009) (Amended to include “midwife” July 18, 1984, *see* P.L. 98-369, 98 stat. 1110) (covering midwifery under Medicare/Medicaid); *see also* Harlow, *supra* note 21.

²⁵⁵ Homebirth-USA, Cost and Insurance Coverage, www.homebirth-usa.org/choosing/insurance.html (last visited Dec. 1, 2008).

²⁵⁶ The American Association of Birth Centers reports that “about 9 or 10 state Medicaid plans pay Direct-Entry Midwives.” *See* American Association of Birth Centers, *Medicaid and Birth Centers: Background Information*, available at <http://www.birthcenters.org/legislative-alerts/index.php?id=17> (last visited Aug. 26, 2009); *See also* Midwifery Alliance of North America, *Direct Entry Midwifery State-by-State Legal Status*, *supra* note 11 (reflecting that 11 states have Medicaid reimbursement).

²⁵⁷ *See* American Association of Birth Centers, *Judge Rules Against Birth Centers*, available at <http://www.birthcenters.org/news/breaking-news/?id=83>. (last visited Aug. 25, 2009) (documenting that the Center for Medicare and Medicaid Services is beginning to disallow federal matching funds to states that pay birth center facility fees). The American Association of Birth Centers reports that as many as 50-95% of some birth center’s patients are Medicaid enrollees. *Id.*

²⁵⁸ WAGNER, *supra* note 4, at 29, 178 (documenting that, in some states, malpractice insurance companies will no longer cover claims resulting from VBAC); Law, *supra* note 6 at 356-59, 368-70 (discussing the factors that gave rise to the VBAC ban in many hospitals & noting that hospital and physician perceptions about risk and malpractice liability reflect a “misunderstanding of the law”). *See generally* Paul, *supra* note 193 (documenting that a 2006 survey reporting that 26% of physicians had stopped VBAC deliveries because insurance was unaffordable or unavailable). Evidence suggests that some mothers are interested in attempting VBAC in areas where it is commonly denied. *Id.* (citing to a New York survey documenting that 57% of mothers would be interested in attempting vaginal delivery); Law, *supra* note 6, at 357 (asserting that “when VBAC is commonly denied, many women who would prefer vaginal birth are denied that choice”); BLOCK, *supra* note 4 at 261 (documenting the plight of women who, as a result of VBAC bans, have their delivery options limited to C-section at a hospital or homebirth with a midwife).

to freestanding alternative birth centers, and make it difficult for alternative birth centers and Direct-Entry Midwives to practice.²⁵⁹

IV. "NEW" OPTIONS PROVIDE A GREATER CHANCE FOR LIMITATION

The government, insurance companies, and health care providers may limit a woman's delivery options.²⁶⁰ In considering these limits alongside the government's growing propensity to protect the fetus, and a distrust of different birth methods, it appears that maternal independence during labor will begin to erode. The following portion will show how elective C-sections, elective induction, and home births further contribute to a decline in maternal autonomy.

A. Home Births

As home births grow in popularity, it is possible that more situations will arise where physicians call upon courts to resolve delivery room conflicts. *Pemberton*²⁶¹ was examined above in detail because it is illustrative of the type of conflict that may arise as home births increase in popularity. Like Ms. Pemberton, many mothers that opt for home births have done so because they trust their natural ability to safely deliver children and prefer to deliver outside of a hospital.²⁶² These strong beliefs, coupled with a distrust of physicians arguably created by aggressive home birth advocates, could increase the number of women who do not wish to undergo any medical intervention during labor. When these women call upon the hospital because delivery stagnates or an emergency arises, they may be more averse to undergoing the physician's recommended treatment. As more situations like this arise, it is possible that more of those rare circumstances will develop where doctors solicit the courts to compel medical treatment. In light of the government's growing propensity to protect the fetus,²⁶³ the commonly misunderstood maternal desire for natural delivery,²⁶⁴ and other commentators suggesting that compelled medical treatment is justifiable,²⁶⁵ more courts may conclude that compelled medical treatment is acceptable.²⁶⁶

²⁵⁹ WAGNER, *supra* note 4 at 228-29; *see also supra* notes 124-25.

²⁶⁰ *See supra* Part III.

²⁶¹ *Pemberton*, 66 F. Supp. 2d at 1247.

²⁶² *See supra* Part II.A.2.

²⁶³ *See supra* Part III.C.

²⁶⁴ Cohen, *supra* note 21, at 858.

²⁶⁵ *See Leavy, supra* note 153, at 98-99 (2005) (arguing that a state should be able to require a woman to undergo a C-section "due to the special relationship formed between the mother and the fetus by the time of viability").

²⁶⁶ Janet Gallagher has identified several commonalities in forced medications cases: medications are often initiated shortly before birth or during labor, the mothers rarely testify directly, and misinformation is common. *See Cohen, supra* note 21, at 866 n.75 (citing to Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong With Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 48-54 (1987)). Many of these commonalities would be present in situations where a mother who chooses to deliver at home seeks minor medical assistance while in the throes of labor.

The home birth movement will also affect mothers choosing to deliver in the hospital. The distrust of physicians and the desire to avoid medical intervention cultivated by the home birth movement could cause women to distrust a physician's determination that medical intervention is necessary. Such beliefs, when coupled with "informed dissent" programs, will lead to combative behavior in the delivery room that could have undesirable consequences.²⁶⁷

Wherever the option is legal, regardless of safety, the choice to have a home birth attended by a midwife is a choice every mother can make.²⁶⁸ So long as the option remains available, interested parties' concerns that home births needlessly risk fetal health²⁶⁹ will always be present. Accordingly, steps should be taken to protect a mother's choice to deliver where she sees fit, without fear of judicial intervention or the adverse consequences of her decision. This Note proposes such steps in Part V.

B. C-Sections & Induced Labor

Elective C-sections and scheduled inductions will adversely affect the independence of mothers hoping to avoid medical intervention.²⁷⁰ It has been asserted that patient-choice C-sections lower or entirely remove the threshold for when a C-section becomes medically necessary.²⁷¹ Because of this lower threshold, doctors may begin to determine that the criteria indicating that intervention is appropriate exist sooner in the delivery process, thereby making mothers more likely to experience a C-section or induction.²⁷² Also, it is possible that a doctor's views about the acceptability of such procedures will be altered by the increasing number of mothers requesting these procedures.²⁷³ The effects of this lower threshold could be further exacerbated by the economic, legal, and personal benefits that physicians receive when they opt to perform a C-section.²⁷⁴

²⁶⁷ This could result in termination of parental rights. *See supra* notes 172-176 and accompanying text. Even if a mother does not aggressively resist certain treatment methods, the chilling effect from previous court decisions may cause her to consent to procedures she does not desire out of fear that combative behavior may result in undesirable consequences. *See supra* note 176.

²⁶⁸ *See, e.g., supra* Part III (explaining that a mother's right to choose her delivery option is a fundamental right protected by the Constitution).

²⁶⁹ *See supra* Part II. Fetal injuries can occur in the home birth setting because it places distance between mothers, skilled obstetricians, and valuable hospital equipment. Also because there is no absolute method that can readily predict if or when a seemingly low-risk pregnancy will turn into a high-risk one, determining that a mother is "low-risk" does not guarantee that the mother will not need skilled medical assistance. Rausch, *supra* note 11, at 229.

²⁷⁰ Professor Law shares this concern. *See Law, supra* note 6, at 380 (suggesting that elective C-sections may lead to diminished maternal choice. "It would be tragic if respect for those choices led to an increase in the number of women pressured to have C-sections.")

²⁷¹ BLOCK, *supra* note 4, at 125 (quoting Howard Minkoff, Chair of Obstetrics and Gynecology at Maimonides Medical Center, Brooklyn, NY).

²⁷² *See Law, supra* note 6, at 380

²⁷³ *Id.*

²⁷⁴ *See supra* Part III.D.

V. RESOLUTION

No delivery method can guarantee a safe and healthy baby. In most births, these “new” delivery options are safe choices that a mother can justifiably exercise.²⁷⁵ However, economic, legal, ideological, personal, and professional interests influence a mother’s choice. As more women deliver using “new” options, it seems possible that these interests will unfairly influence delivery decisions.

Numerous scholars have concluded that the mother is the best person to decide how to deliver her child,²⁷⁶ and legal and medical standards are often in accord with this position. But making the appropriate decision in light of numerous influences and limitations can be challenging. A culture of physician distrust and uncertainty about the safety of home births leaves some mothers without desirable options. For some, the choice boils down to delivering in the hospital and risking unnecessary intervention or injury, or delivering outside the hospital²⁷⁷ and risking injury because skilled physicians and instruments are not readily available. Consequently, some mothers are forced into choices that could result in physical and emotional injuries.²⁷⁸ And while the circumstances underlying these problems cannot be totally eliminated, the state can take several steps to ensure that delivery decisions are well-informed, made free from coercion, and without fear of negative repercussions.

A. Empowering the Mother as A Decision Maker

1. Increase the Information Available

The first way to protect mothers against the adverse effects of these “new” delivery options is to increase the information made available to mothers.²⁷⁹ As discussed above, only two states currently require that hospitals disclose their C-section and induction rates.²⁸⁰ In the past, concerted efforts to enact similar legislation in other states have been stymied by powerful medical lobbies.²⁸¹ Margaret Donohoe has suggested that information be physician specific, as a means to curb unnecessary C-sections.²⁸² Ms. Donohoe posits that making this information available would help create market forces that could influence hospitals away from C-section overuse and help women understand that C-sections are not always necessary or appropriate.²⁸³ In furthering Ms. Donohoe’s suggestion, caregiver-

²⁷⁵ Law, *supra* note 6, at 346.

²⁷⁶ See generally Cohen, *supra* note 21, at 854 (arguing that, given the mother’s strong privacy interests and parental rights to the developing child, the mother-to-be is the best childbirth decision maker); Harris, *supra* note 86; Law *supra* note 6, at 362; WAGNER, *supra* note 4, at 205-07.

²⁷⁷ BLOCK, *supra* note 4, at 261.

²⁷⁸ Injuries could occur in either the delivery or the home birth setting.

²⁷⁹ Donohoe, *supra* note 6, at 237; WAGNER, *supra* note 4, at 205-09.

²⁸⁰ See *supra* note 132.

²⁸¹ Donohoe, *supra* note 6, at 238; WAGNER, *supra* note 4, at 11.

²⁸² Donohoe, *supra* note 6, at 238-39.

²⁸³ *Id.* at 237.

specific information should also be made available for Certified Professional and Direct Entry Midwives.²⁸⁴ Having this information available on a midwife-specific level would result in a better public understanding of the safety of out-of-hospital midwife delivery, both for individuals considering delivery with a midwife and for legislators looking for evidence regarding midwife safety. A better understanding of midwife safety could result in fewer women being subject to unnecessary in-hospital procedures. At the same time, making safety information available to the public might deter midwives from attending risky deliveries that should take place in the hospital.

Additional beneficial information could also become available by documenting the number of “pushed births” at a given hospital. In 2005, Florida approved a constitutional amendment giving patients access to records related to “adverse medical incidents.”²⁸⁵ This amendment “represents one of the most sweeping changes in law and public policy ever adopted in [Florida].”²⁸⁶ Amendment 7’s purpose is to “create a constitutional right for a patient or a potential patient to know and have access to records of a health care facility’s or provider’s adverse medical incidents, including medical malpractice and other acts which have caused or have the potential to cause injury or death.”²⁸⁷ A Florida court has defined “adverse medical incidents” to mean “medical negligence, intentional misconduct and any other act, neglect, or default of a health care facility that caused or could have caused injury or death to a patient”²⁸⁸ It could be argued that compelling mothers to undergo unnecessary procedures constitutes an adverse medical incident worthy of documentation.²⁸⁹ By attempting to document the number of “pushed births,” mothers angered with the way their delivery was managed would have a formal avenue to voice their discontent, the public would have a way to investigate the coercive nature of physicians, and physicians would be further dissuaded from coercing mothers into undergoing unnecessary interventions.

2. Encouraging Disinterested Involvement

It is well settled that the government “has an interest in protecting the integrity and ethics of the medical profession.”²⁹⁰ If the criticisms about physicians pushing patients into invasive procedures or misleading mothers about their choices are

²⁸⁴ Hospital transfer rates, documentation of adverse medical outcomes, etc.

²⁸⁵ FL. CONST. art. X § 25.

²⁸⁶ J.B. Harris, *Riding the Red Rocket: Amendment 7 and the End to Discovery Immunity of Adverse Medical Incidents in the State of Florida*, 80 FLA. BAR. J. 20 (2009).

²⁸⁷ *Id.* at ¶ 6 (citing to *Advisory Opinion to the Attorney General re: Patient’s Right to Know About Adverse Medical Incidents*, 880 So.2d 617, 619 (Fla. 2004)).

²⁸⁸ *Id.* at ¶ 10 (citing to *Florida Hospital Waterman, Inc. v. Buster*, 932 So. 2d 344, 350 (Fla. 5th Dist. Cr. App 2006)).

²⁸⁹ Accusations would first have to be reviewed for merit.

²⁹⁰ *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997); *see also Barsky v. Board of Regents of Univ. of N. Y.*, 347 U.S. 442, 451, (1954) (indicating that the State has a “legitimate concern for maintaining high standards of professional conduct in the practice of medicine”).

valid,²⁹¹ then some health care providers have brought the medical profession's integrity into question.²⁹² To restore and protect this integrity, a state-supported, disinterested maternal education program should be developed to encourage disinterested physicians and midwives to cooperatively educate individual mothers about the particular risks and benefits of their available delivery options and rights. By requiring mothers early in pregnancy to consult with a state supported physician-midwife panel that is not ultimately responsible for her care, the state could negate the effects of aggressive birth advocates, eliminate concerns that physicians are providing mothers with inadequate or improper information, and expose mothers who had never considered delivery with a midwife an opportunity to interact with a caregiver who applies a different philosophical approach to childbirth. Additionally, more education may result in greater maternal independence in the delivery room, because mothers may be able to communicate better with their physicians, and physicians may have a greater respect for the mother's delivery choice. Likewise, home births will be safer because mothers will better appreciate the risks of delivering outside the hospital, and will have more knowledge to draw upon that will enable them to recognize and appreciate signs of trouble.²⁹³

B. Incentivize More Appealing Birth Conditions

A second way to protect mothers against the adverse effects of these "new" delivery options is to offer economic incentives to make all labor options more appealing. Freestanding alternative birth centers offer some mothers the freedom they desire,²⁹⁴ but are not available everywhere.²⁹⁵ Where they are, high malpractice premiums and changes to Medicaid are making it difficult for poorer mothers to exercise the option.²⁹⁶ Currently, bills to amend Title XIX of the Social Security Act to require coverage for freestanding alternative birth centers under the Medicaid program are before both the United States Senate and House of Representatives.²⁹⁷ Passing this legislation would make freestanding alternative birth centers more accessible to mothers with strong anti-intervention beliefs, but who cannot afford the option without governmental aid. Furthermore, additional economic incentives should be directed towards subsidizing the high malpractice premiums that

²⁹¹ See *supra* notes 124-25 and accompanying text.

²⁹² The medical community has made commendable strides to ensure that coercion does not occur. See Law, *supra* note 6, at 367. Nevertheless, criticisms of physician coercion persist. Cf. Paul, *supra* note 193. By having disinterested, qualified physicians & midwives cooperatively educate mothers, criticisms regarding coercion would be greatly reduced.

²⁹³ The midwife approach requires the mother to take more responsibility for her own care and education. Hermer, *supra* note 16. This Note does not contend that mothers are currently uneducated, but instead suggests that hands on education with a trained obstetrician and midwife during pregnancy will only further benefit the mother.

²⁹⁴ WAGNER, *supra* note 4, at 133, 137.

²⁹⁵ See, e.g., BLOCK, *supra* note 4, at 106, 267.

²⁹⁶ See *supra* notes 124-25 and accompanying text.

²⁹⁷ Medicaid Birth Center Reimbursement Act, H.R. 2358, 111th Cong. (2009); Medicaid Birth Center Reimbursement Act, S. 1423, 111th Cong. (2009).

physicians must pay when they allow mothers to attempt to deliver vaginally after a C-section or when they provide backup services to a freestanding alternative birth center.²⁹⁸

C. Rethinking Informed Consent

A final way to protect mothers against the potential adverse effects of these “new” birth options involves adopting a reshaped perception of informed consent in the childbirth arena. Adopting the conception of informed consent articulated in *Schreiber*²⁹⁹ will foster a more cooperative physician-patient relationship. Such a continual, dialogue-driven informed consent process is consistent with the overall progression towards greater maternal autonomy throughout pregnancy,³⁰⁰ and Professor Law’s conclusion that women’s voices be given greater weight in birthing decisions.³⁰¹ This approach, when coupled with the education proposed within this Note,³⁰² can help eliminate coercive physician treatment, facilitate maternal trust in physician decision-making, and aid in restoring the integrity of the medical profession.

VI. CONCLUSION

As mothers are given more freedom to make their delivery choices, problems with the current maternity care system and the legal protections afforded fetus have the potential to diminish maternal independence. At one end of the spectrum, the home birth movement and reactions against “medicalized” birth have the potential to create physician distrust and a greater resistance to medical treatment. This resistance, when coupled with an expansive view of fetal rights may result in compelled medical treatment, injury, or the loss of parental rights. At the other end of the spectrum, elective C-sections and inductions will diminish the likelihood that mothers who wish to avoid medical intervention will be able to do so.³⁰³ Somewhere in between, the fears surrounding birth are precluding mothers from exercising viable options from the living room to the delivery room. A three-part solution has been proposed to alleviate these problems. Taken together, these three prongs will empower women to make better-informed birth decisions, hold physicians and midwives more accountable, and create a more cooperative relationship between physician and patient.

²⁹⁸ See *supra* notes 124-25 and accompanying text.

²⁹⁹ *Schreiber*, 588 N.W.2d at 26.

³⁰⁰ See *Ketler, supra*, note 3.

³⁰¹ *Law, supra* note 6, at 362

³⁰² The state can teach patients precisely what situations trigger the legal or medical change in circumstances that necessitate further informed consent when it educates mothers through the solution proposed herein.

³⁰³ This Note agrees with Professor Law in reaching this conclusion.